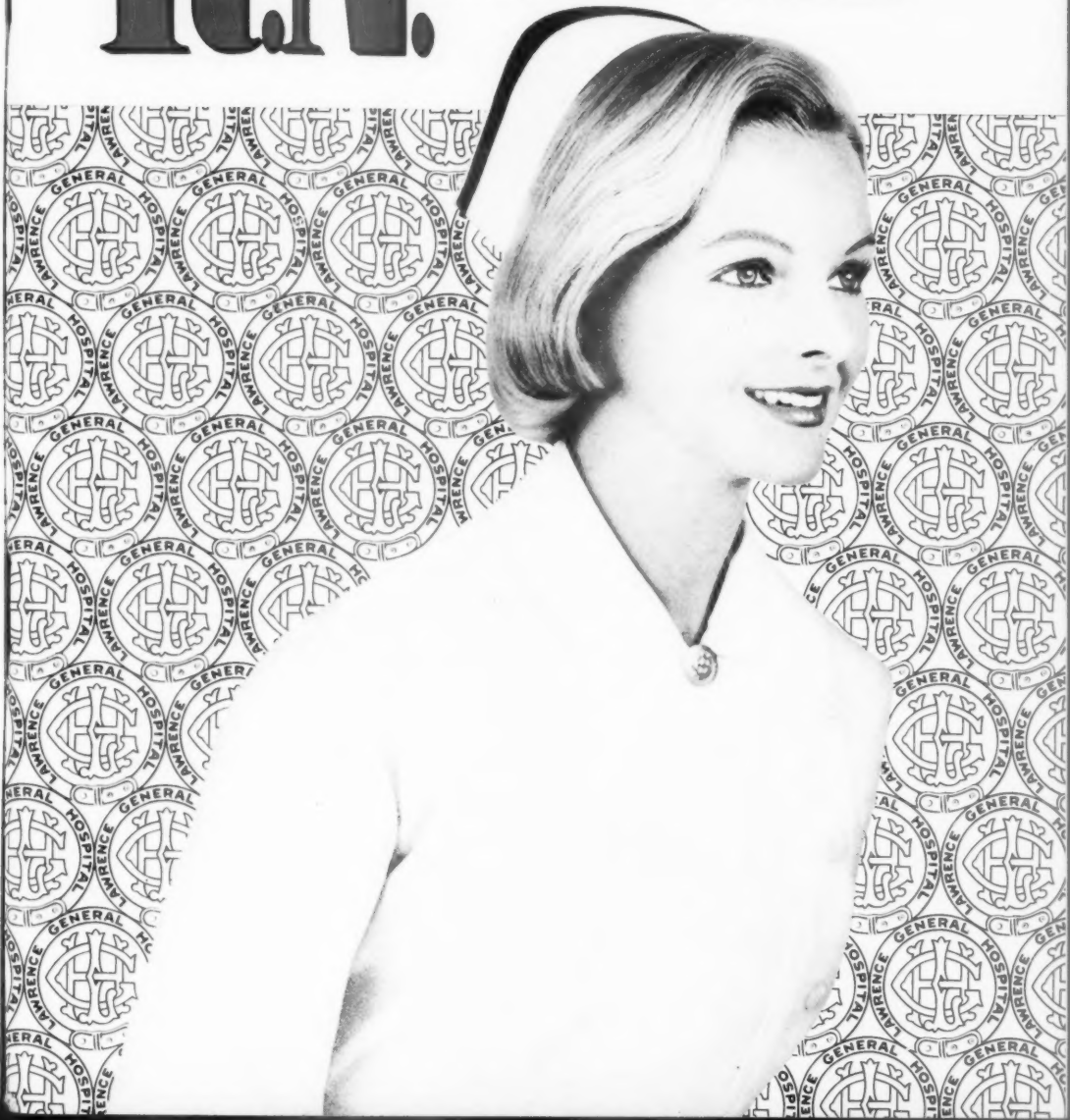
R.N.

A JOURNAL FOR NURSES

FEBRUARY 1957



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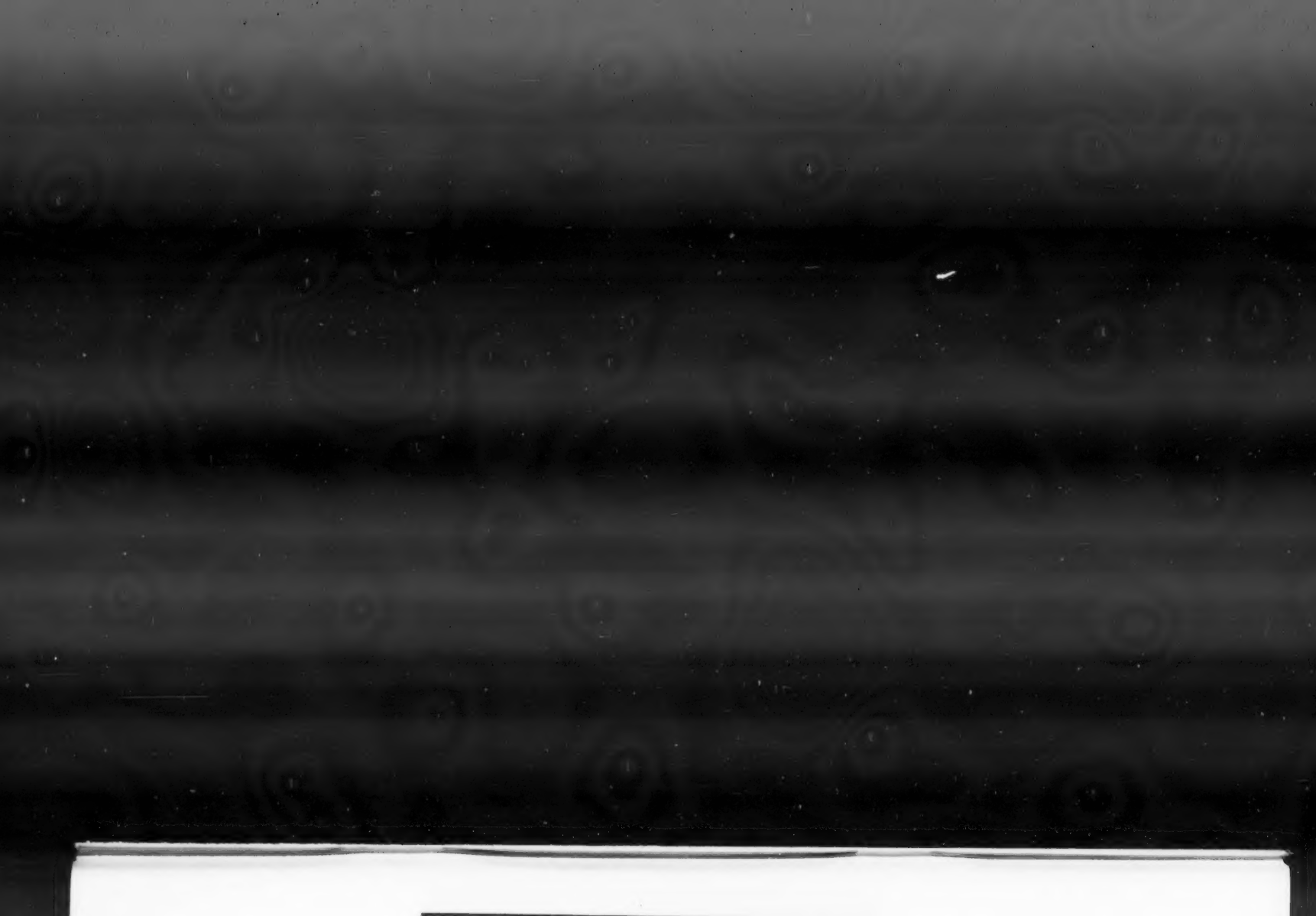

R.N. A JOURNAL FOR NURSES

CONTENTS

R.N. Feb. 1957; Vol. 20, No. 2. Published monthly by The Nightingale Press, Inc. Oradell, New Jersey. Subscription $2 a year; 25c a copy; Canada and foreign countries $3 a year; address: R.N., Rutherford, New Jersey. Entered as second class matter, Nov. 20, 1951, at the post office at Rutherford, N.J. under the act of March 3, 1879.

EPA NBP

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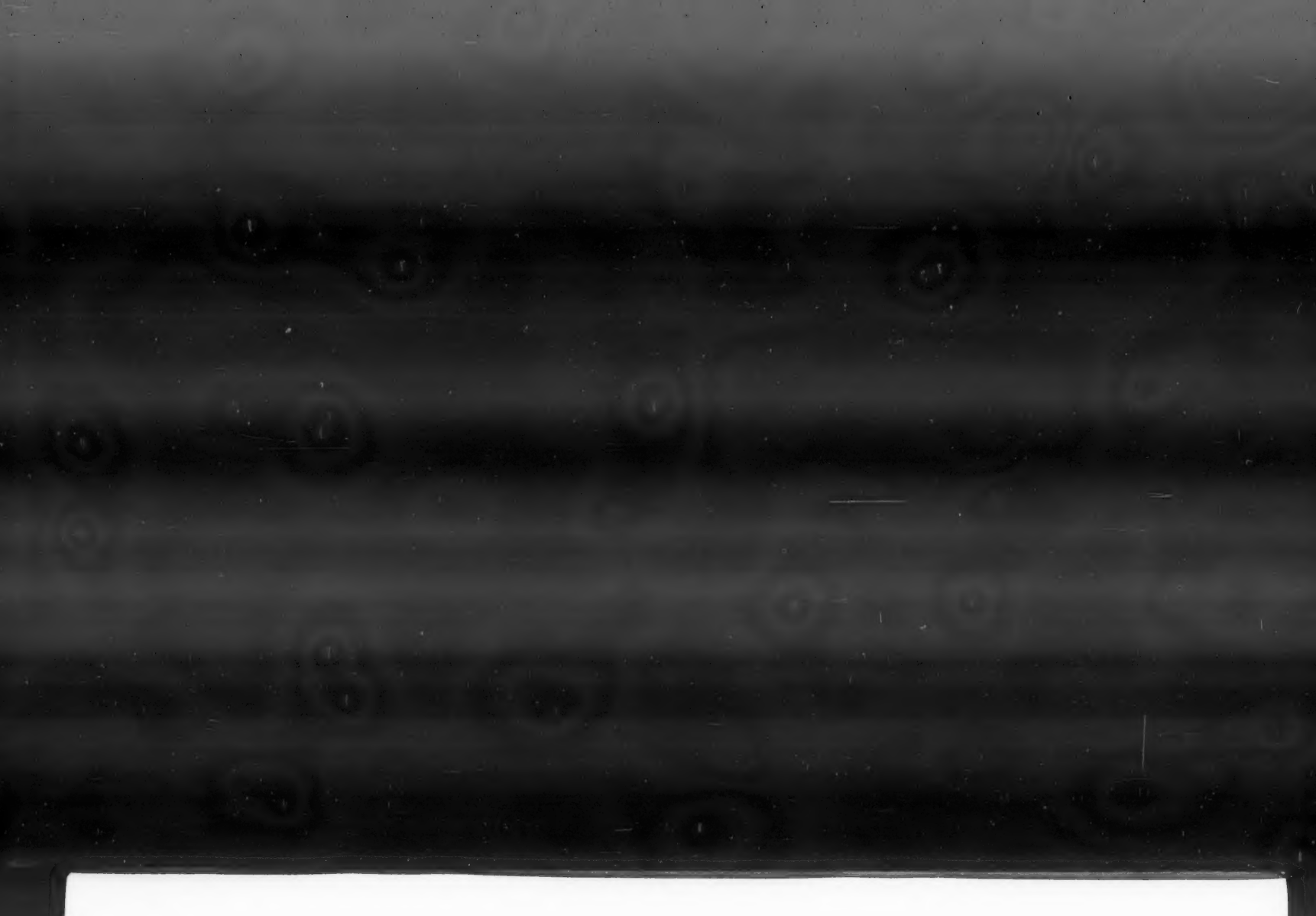
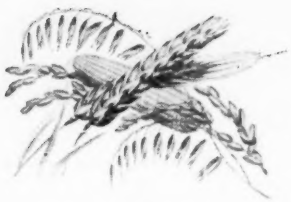
CREDITS: ***Cap, pin, and uniform: Lawrence General Hospital School of Nursing. Cover photographer: Walter Herstatt. Photographs: Standard Photo Service Company (page 36); Darling-Richard and Company (page 39).***



THE COVER

In 1882, seven years after Lawrence General Hospital was founded in Lawrence, Massachusetts by the Ladies Union Charitable Society, the School of Nursing was opened with one student. Two nurses comprised the staff, and the next year five more students were admitted. In addition to weekly lectures and instruction from physicians, a class in cookery was conducted by Miss Fanny Farmer of the famed Boston School of Cookery. Important roles in the initial organization and direction of the school were assumed by Miss Florence I. Rice and Miss A. E. Andrews. In the seventy-five years since its founding, the Lawrence General Hospital School of Nursing has grown rapidly. Graduates of its three-year course hold responsible positions throughout the country and in many government services. The school's pin, with the letters "LGH" entwined in the center, was worn by the first graduate in 1884 and is the official seal of Lawrence General Hospital and the School of Nursing. »»



Are you interested in a Low-Fat Breakfast?

In the dietary regimens recommended by nutrition and medical authorities for the purpose *of reducing fat in the diet* the importance of the morning meal is given full recognition. That a low-fat breakfast should be adequate not only in calories, but also in its content of essential nutrients, is advocated by medical as well as nutrition authorities.

The basic cereal breakfast pattern shown below *is low in fat and low in cholesterol* and makes a worth-while contribution of complete protein, essential B vitamins, and minerals. Thus it merits inclusion in dietary regimens for the purpose of reducing fat in the diet.

BASIC CEREAL LOW-FAT AND LOW-CHOLESTEROL BREAKFAST PATTERN

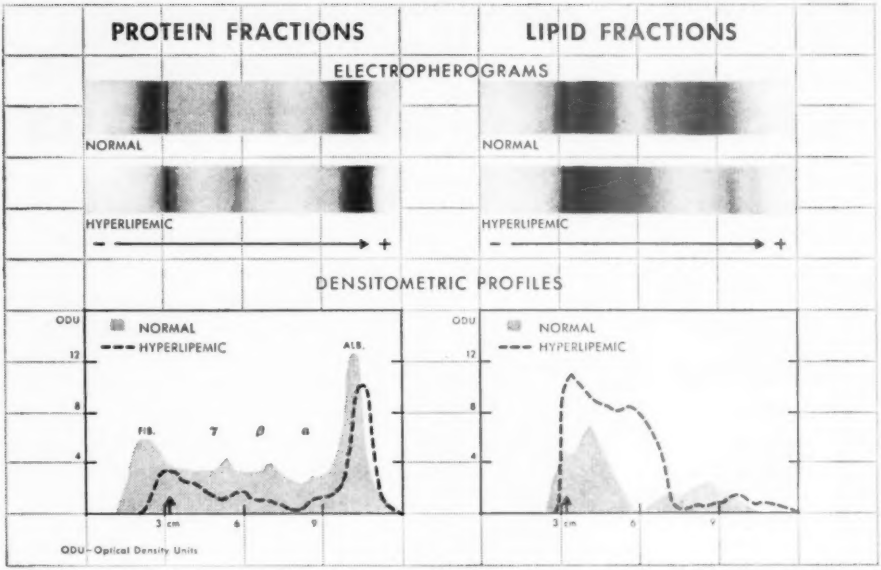
Orange juice, fresh, ½ cup, Cereal, 1 oz., with whole milk, ½ cup, and sugar, 1 tsp., Bread, white, 2 slices, with butter, 1 tsp., Milk, nonfat (skim), 1 cup, black coffee.

Nutritive Value of Basic Cereal Breakfast Pattern

Calories	502
Protein	20.5 gm.
Fat	11.6 gm.
Carbohydrate	80.7 gm.
Calcium	0.532 gm.
Iron	2.7 mg.
Vitamin A	600 I. U.
Thiamine	0.46 mg.
Riboflavin	0.80 mg.
Niacin	3.0 mg.
Ascorbic Acid	65.5 mg.
Cholesterol	32.9 mg.

Note: To further reduce fat and cholesterol use skim milk on cereal which reduces Fat Total to 7.0 gm. and Cholesterol Total to 16.8 mg. Preserves or honey as spread further reduces Fat and Cholesterol.

Bowes, A. deP., and Church, C. F.: Food Values of Portions Commonly Used. 8th ed. Philadelphia: A. deP. Bowes, 1956.
Cereal Institute, Inc.: The Nutritional Contribution of Breakfast Cereals. Chicago: Cereal Institute, Inc., 1956.
Hayes, O. B., and Rose, G. K.: A Supplementary Food Composition Table for Dietary Studies. J. Am. Dietet. A.: Jan. 1957.



BLOOD DRAWS ITS OWN PROFILE

Here's one of the most ingenious methods of blood analysis! A small strip of paper in an electric field paints a picture that's worth a thousand calculations!

Principle: **The phosphatides and phosphatide-containing complexes travel along the electrified path of the paper strip allowing identifiable protein and lipid complexes to be deposited at various points. Where the phosphatide content is insufficient, electroneutral lipids (cholesterol, neutral fat) are set free to remain at the starting point. Thus we obtain the characteristic tell-tale density zones of the electrophoretic profile.**

Significance: **Paper electrophoresis provides demonstrable physical evidence in disturbances of lipid metabolism and in associated disease states. Characteristic patterns have been obtained in hypercholesteremia, hyperlipemia, lipoid nephrosis, etc.; electrophoretic profiles from various species illustrate their relative predisposition to atherosclerosis.**

Application: **Paper electrophoresis is now being used to investigate the influence of dietary supplementation with "RG" Lecithin upon lipoprotein patterns in patients with lipid metabolism disturbances.**

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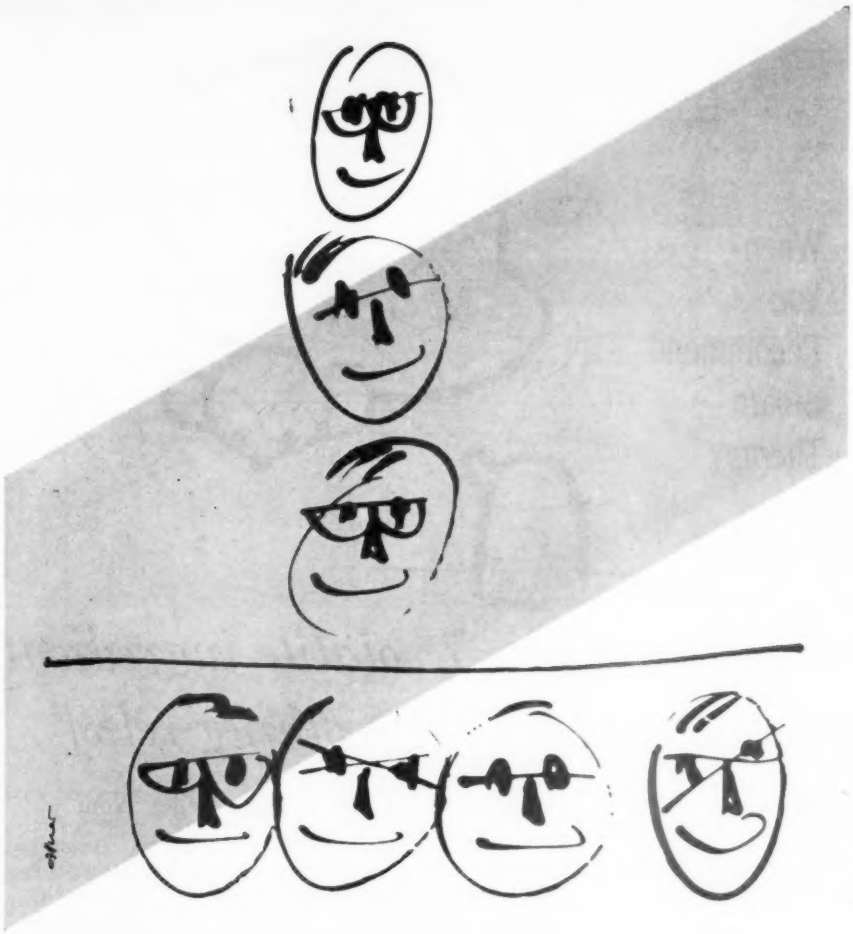

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LETTERS

SUCCESSFUL COMBINATION
Dear Editor:

Your articles on part-time nursing are of special interest to me. I have two small children and I work part-time at the local hospital. I think all nurses should keep in touch with the profession as it gives one a feeling of satisfaction that nothing else can.

(Mrs.) Vera Kalberer, R.N.
GARY, INDIANA

WHERE WILL IT END?
Dear Editor:

Uniforms for nurses are following a style trend, but isn't there a limit? The sheaths, the tight bodice, the fluted skirts with slits, etc., not to mention the shoes! And what about the sheer uniforms with the strapless bras? Where will it end?

Helen McCombs, R.N.
SOUTH OZONE PARK, N.Y.

FOR PRACTICAL NURSES
Dear Editor:

As a patient, I can see those of my profession carrying on with a shortage of help and without time to plan their work or to obtain an objective viewpoint of the patients' problems. The salaries in this hospital are good but the R.N.'s do not stay. Why? There is too much stress and strain. An active practical nurse program would certainly help and would keep the staff stable. And what about one coffee hour a week so they could meet and discuss work problems? This would prevent many outbursts of pent up feelings on the part of the staff.

(Mrs.) Irene Bilgen, R.N.
NEWPORT, RHODE ISLAND

IT CAN HAPPEN
Dear Editor:

I was formerly head nurse in a surgical unit of a large West Coast hospital. Recently I returned to staff nursing at a small rural hospital in Sharon, Conn. It's certainly good to be back where the spirit of good old bedside nursing prevails, and where the patient comes first. Even our nurses with advanced training are interested in "T.L.C." —working alongside the practical nurse and finding her an ally, not a foe.

We haven't enough nurses to do team-nursing, but we all do our share in helping one another and in keeping the patients comfortable and contented. It's a pleasure to

work where the situation isn't as it is in many large hospitals: "Too many Chiefs and not enough Indians." God bless the country hospitals and country doctors!

I feel that we practice what so many merely preach. We are giving the best possible nursing care with a minimum of friction among the personnel; we are keeping the old spirit of nursing alive—for no one, from the directress down, is above giving a back-rub, smoothing a pillow, or handling a bedpan. Instead of worrying about who gets promoted next (and why), each of us is striving to do her very best.

Your magazine is a help to all of us.

MARIANA E. HOLLADAY, R.N.
CANAAN, CONN.

PRACTICAL IDEA

Dear Editor:

I admire many practical nurses. Some are thorough, efficient, and give good care. On the other hand, all of them do not fit into an admirable category. How may we protect the good ones and eliminate the bad?

I suggest that all practical nurses be required to pass written and oral examinations when applying for hospital jobs—just as students are required to pass certain tests before admission to a nursing school. Such exams would eliminate some of the difficulties that arise later—such as tendencies toward alcoholism, mental illness, drug addiction, kleptomania, and other disorders. The accepted nurse

could then be proud of her group, and would see its standards raised.

Also: Each patient receiving private duty care has the right to know who that woman in white is when she comes to take his case. He should ask to see the "R.N. card" that shows her registration number. As things stand now, the patient orders nurses and hopes for the best. He has the right to *know*.

(Mrs.) Grace Stewart, R.N.
BRENTWOOD, MO.

ACTIVE AGAIN

Dear Editor:

It is a pleasure to renew my subscription for two years. R.N. is impressive because of its varied subjects and intelligent material: it helps "old timers" like myself to reflect and remember. I recently returned to private duty after being inactive for twenty-five years. At times I also do general duty at a new convalescent and nursing home. Hence I find your magazine (as well as the literature sent for) very instructive and helpful—especially the new drug information.

(Mrs.) M. G. Mandeville, R.N.
FLAGTOWN, N.J.

'VANISHING HEART'

Dear Editor:

Have just read "The Vanishing Heart of Nursing" in the October issue. We R.N.'s of today are being misjudged. This article is most unfair. Nursing service has changed greatly in the past five years, and tomorrow there will be even more drastic changes to meet the terrific

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nursing shortage. We are now responsible for more than bed baths, temperatures, and enemas. Now, we not only give specific treatments such as irrigations and I. V. fluids but we also know their immediate value, reaction and result. Moreover, we are expected to report efficiently to the doctor in charge. Did you know that we are often responsible for 50 to 80 patients?

(Mrs.) Mary Griffiths, R.N.
CANAL ZONE

* * *

Dear Editor:

I read "The Vanishing Heart of Nursing" in the October issue. I am pleased that an R. N. has finally voiced the actual cause of so much confusion and discontent in nursing. I would like to join with all nurses throughout the U. S. and help make us "United Nurses" with no "Vanishing Heart". Seems to me that nursing schools are turning out very efficient bookkeepers and stenographers today. They forget our mission of caring for the sick.

Oleta M. Graham, A.N.C.
DALLAS, TEXAS

* * *

Dear Editor:

Hats off to Emma Harling for "The Vanishing Heart of Nursing." There are some nurses, especially older nurses, who really had training that made nurses of us instead of models in uniform. I am not a perfect nurse but it is a great satisfaction to go off duty and know what the next shift will or will not

find when lifting the patient's covers.

(Mrs.) Helen M. Buker, R.N.
Oregon, Ill.

WHO'S AT FAULT?

Dear Editor:

I read much condemnation of the practical nurse—a title which seems to be applied to the untrained worker as well as to the trained.

I am appalled when I hear of untrained workers who, after a few weeks' training at the bedside, are assigned to duties far above their abilities. They do not realize their limitations and should not be condemned as much as the supervisor, (usually an R.N.) who sets them to such tasks. Yet the supervisor may be at her wits' end to care for patients; she may be unable to employ a stable staff of R.N.'s if her hospital is in a small town that has no attraction for city-trained nurses.

Many small communities have built hospitals with the aid of federal funds. When the legislation to provide such funds was before Congress, did our national nursing organizations do anything to emphasize the need for trained staffs? If not, why?

I hold no brief for poor nursing service from either the R.N. or the auxiliary worker. But I definitely believe there is a place for the well-trained practical nurse. She should be ingrained with the knowledge that she is to work only under close

supervision of an R.N. or M.D. She should know her limitations and honestly live by them—not accepting assignments she is unqualified to fill. No practical nurse should be left in charge of any department; if she is, the person who so assigns her is at fault.

MARGARET R. KIRKPATRICK, R.N.
DIRECTOR, PRACTICAL NURSE TRAINING PROGRAM
TEXAS STATE COLLEGE FOR WOMEN
DENTON, TEX.

BLUE RIBBON NURSE

Dear Editor:

Your October issue was thought provoking. Hospitals can increase staff efficiency by a coffee hour every week for discussion of small details and treatments of diseases. Some of the medical journals, such as the *New England Journal of Medicine*, also help me to understand more about diseases. A doctor needs a nurse who is observant and she can only be intelligently so if she is informed. My blue ribbon goes to the nurse who cares for her patient. Neither degrees nor legislation can give it to the nurse who lacks it.

CAROLYN M. RAFFENSPERGER, R.N.
CHICAGO, ILL.

FUTURE NURSES

Dear Editor:

A "Future Nurses" Club is part of the extracurricular program of our high school. It is a product of the scholarship program our Business and Professional Woman's Club originated some years ago.

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It is an interesting program, and certainly is a very good promotional program for the profession. And we've had wonderful cooperation from high school teachers and members of the club.

(Mrs.) Olga R. Hodgson, R.N.
KANKAKEE, ILL.

REFRESHER RESULT

Dear Editor:

About four years ago, the San Antonio League for Nursing Education offered a refresher course for old, retired nurses. With seven others, I took the six-weeks course. (We all finished.) It was wonderful. As a result, I have a lovely position at the hospital here—after not nursing for twenty years. It's wonderful nursing today, and I'm still learning!

Miriam T. Neiman, R.N.
SAN ANTONIO, TEX.

MORE ABOUT MICKEY

Dear Editor:

Pictured in your September issue is a familiar face—that of the courageous mother of little Mickey Boyle. I knew her when I lived in San Leandro. At the time, Mickey was only about two years old, and his worried parents had to decide to have his second eye removed to save his life. R.N.'s readers now know what marvelous results ensued—not only for Mickey but for other sightless

children. The Boyles' courage in the face of what might have been despair makes our own problems seem puny and our complaints unjustified.

KATHLEEN S. REESE, R.N.
MENDOCINO, CALIF.

'GIFTS OF THE HEART'

Dear Editor:

I have just read and reread your Christmas editorial. It is really inspiring and inspired. I send this expression of thanks because I know that your subscribers, all of them, would say the same thing if only they took the time to write and tell you so.

Someone has said, "Away in the hidden depths of every soul is the secret gleam of a perfect life." That was never said more truly of anyone than it is of you. You write so sincerely and with such depth of feeling that it makes your readers a little bit weepy inside for the sheer beauty of it. Certainly, we here feel that you have given us a beautiful thought to hold close all the year.

In all our churches on Christmas Eve and Christmas Day thousands of priests and pastors will try to express the thought that you carried in those two small pages of your December issue. I am sure that none will say it more beautifully than you did in your Christmas editorial.

MAJ. DORIS F. JENSEN, ANC
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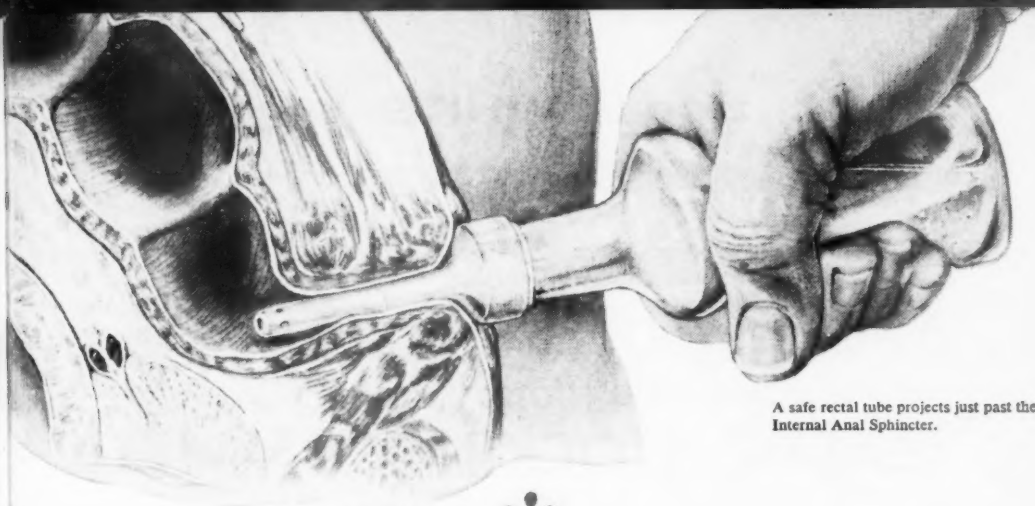

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(1) Swinton, N.W., Surg. Clin. of No. Am., 35:833, 1955
(2) Gross, J.M., Jl. Int. Coll. Surg., 23:24, 1955

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LITERATURE & SAMPLES

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SURGICAL SUPPORTS: A helpful brochure on scientific supports, maternity garments, post-mastectomy, maternity and Cordtex bras. Illustrated booklet gives complete description and purpose of each garment. A useful aid to patients' support problems. SEARS ROEBUCK & Co. **A 2**

LOW SODIUM DIETS: Soups, cereals, meats, vegetables—these and other food items are prepared for persons on salt-restricted diets. This folder will point out many ways to avoid diet monotony and maintain the patient's morale. CHICAGO DIETETIC SUPPLY HOUSE, INC. **A 3**

SUTURES: D & G Surgical Specialties and Sutures are described, illustrated and priced for the convenience of nurses interested in the procurement of such items, in the current *Product List* of AMERICAN CYANAMID CO., SURGICAL PRODUCTS DIVISION. (Formerly Davis & Geck). **A 4**

FOR ELDERLY PATIENTS: L-Glutavite is described as a cerebral tonic and metabolic stimulant which is useful in geriatric practice where apathy, fatigue, depression and anorexia are present. Descriptive literature. GRAY PHARMACEUTICAL CO., INC. **A 5**

DESENSITIZING TOOTH PASTE: New, ethically promoted Thermodent is indicated for tooth pain (dental hypersensitivity) from hot or cold food or beverages. This condition often accompanies receding gums, faulty occlusion, or improper brushing. Samples and literature available. THOS. LEEMING & CO., INC. **A 6**

TREATS FOR DIETERS: This is the title of a four-page, attractively illustrated recipe folder containing tips for appetizing uses of D-Zerta and D-Zerta Puddings in low-calorie and diabetic diets. Of interest to nurse or patient. GENERAL FOODS CORP. **A 7**

ABSORBENT PAPER PRODUCTS: Here's an illustrated catalog of many items useful in hospital and home nursing practice. All sorts of tissues, towels, pads, and cellulose rolls. Price list and shipping information included. SOFTISH PRODUCTS, INC. **A 8**

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R.N.—A JOURNAL FOR NURSES
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February, 1957

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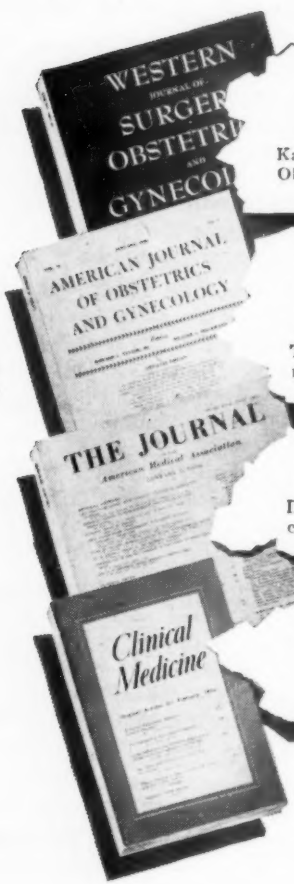

"Free from harm or irritation to the vaginal and cervical mucosa."

Karnaky, K. J.: Western Journal of Surgery, Obstetrics and Gynecology, Vol. 51, pp. 150-152.

"No evidence that the use of the tampon caused obstruction to menstrual flow."

Thornton, M. J.: American Journal of Obstetrics and Gynecology, Vol. 46, pp. 259-265.

"Does not impair standard anatomic virginity."

Dickinson, R. L.: The Journal of the American Medical Association, Vol. 128, pp. 490-494.

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Sackren, H. S.: Clinical Medicine, Vol. 46, pp. 327-329.

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A Passing Phase in Nursing's Evolution?

Before a special season and a special issue interrupted our editorial probing of the R.N.'s role in modern nursing, we stated that the profession is in a painful state of transition; that the increase in administrative and supervisory functions has been accompanied by a proportionate decrease in job satisfaction for nurses who traditionally have found gratification in giving direct nursing care to their patients. In their opinion, supervising the work of auxiliaries or nursing through others is not a rewarding substitute, nor is it what nursing is or should be.

To answer innumerable queries, our November editorial was written to identify the trend, not to condone it. Nor was its purpose to agree with those nurses who erroneously limit their interpretation of total nursing to the giving of physical care. Bedside nursing means much more than merely tending to the physical needs of a patient. Unfortunately for the patient and for the health of the profession, the staffing patterns of too many hospitals are based on this limited kind of thinking.

We now raise two basic questions: (1) Do nurse-educators sincerely believe that direct nursing service was just a passing phase in the evolution of nursing—a necessary step toward a professional goal? (2) Is the student nurse's curriculum so designed that she gives bedside care only to prepare her to teach and to supervise others when she has been graduated?

EDITORIAL

Depersonalized service and indirect nursing care are the trend, we are convinced. But we are equally convinced that the combination of dissatisfied patients and dedicated nurses can divert this trend before it reaches the irreversible extreme.

The protests of dissentient patients are already being voiced in newspapers and magazines, in open forums and private bridge parties, and whenever a syndicated columnist is hospitalized.

Throughout the "meetingest" decade in the history of nursing, we nurses have become conditioned convention-goers; ever hopeful that one of our professional speakers, through a stroke of genius, will hit upon a solution to our chronic professional perplexities. It could be that we should now take time out from listening to one another and start listening to what our patients are saying.

Many a patient believes the professional nurse is shirking her duties—duties which to him symbolize her role as an idealized mother. He loses confidence in, and is bewildered by, the present-day nurse who does her "mothering" through others.

If the patient expects personal, tender ministrations from the R.N., but instead receives them from others of lesser professional (or subprofessional) status, is it not natural for him to feel neglected and dissatisfied, regardless of the quality of the care? As he sees it, the aide, the practical nurse, and even the nursing

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The Ruth Hardy Story

by Al Graham

Attractive, grey-haired, and Texan, Ruth Hardy is one of the most unusual, and courageous, industrial nurses in the nation.

Examples of personal courage are no rarity in the annals of nursing; yet it wouldn't be easy to find, in this or any other field, a more genuinely courageous individual than Ruth Hardy, R.N.

Some seven years ago, this attractive, soft-spoken nurse met with a tragic accident that resulted in total blindness. The difficult months that followed became nightmarish years as she underwent a long series of medical and surgical treatments—including a corneal transplant—which failed to restore her sight. Yet neither the catastrophe itself nor its discouraging aftermath has deterred Ruth Hardy from resuming a useful life. Today, in the three-fold capacity of industrial nurse, instructor, and supervisor, she is a key staff member at the Houston-Harris County Lighthouse for the Blind, a Houston, Texas, rehabilitation center, where vocational training and other important services are made available to the county's known total of 2,242 sightless persons.

Following her unsuccessful surgery, and prior to joining the Lighthouse staff, Miss Hardy supplemented her long experience as a nurse by advanced study for a B.S. degree at the University of Houston College of Nursing. At the same time, she also took up the study of ceramics and sculpture—becom-

ing the first blind person the university ever enrolled in these subjects.

The many-sided aspects of Miss Hardy's work at the Lighthouse can be better appreciated if we first have a brief look at the scope of the Houston program—whose current participants number close to 200 totally or partially blinded persons, including eleven of the fourteen instructors and supervisors.

Among the participants are sixteen children of preschool age who regularly attend the Lighthouse nursery school; seventy other youngsters who receive instruction in their own homes from Lighthouse teachers; a group of sightless mothers who are enrolled in a home-nursing course conducted by Miss Hardy; and—representing the program's main activity—various groups of vocational trainees, ranging in age from 13 to 76, who receive workshop instruction in a large number of useful pursuits (such as the cane-seating of chairs, the hand-tooling of leather, and the repair of certain kinds of refrigerating units). The program also includes instruction in the reading and writing of Braille; in typing and bookkeeping; in procedures that enable blind people to operate newsstands and similar concessions in public buildings; and in various arts and crafts—including a course in ceramics, also conducted by Miss Hardy.

As an experienced industrial nurse, the sightless R.N. maintains the Lighthouse dispensary, administering first aid to those who incur injuries in the various workshop departments, and otherwise attending to the immediate needs of those with headaches, colds, emotional upsets, and so on. Injuries, oddly enough, are relatively rare among blind people, who seem to exercise more caution than sighted workers do in handling workshop tools and materials. Thus, in a recent month, out of 176 cases that Miss Hardy cared for in the dispensary, only thirteen were injuries—and six of these were results of minor accidents outside the Lighthouse. By way of contrast, she had seventy-six patients with headaches, forty-seven with colds, and thirty-six with emotional upsets that same month.

"Our most frequent injury," she explains, "is laceration of the face—usually of the cheek. Our blind people have the bad habit, common among the sightless, of trying to look closely at what they are doing. Hence, those who work at the cane-seating of chairs frequently stick themselves in the face with the pick they use on the job.

"Another workshop injury recurs fairly often in our service department, where we often repair soft drink bottle crates for a number of local firms. The metal bands

around these crates sometimes spring back when trimmed off, causing cuts on the arm or hand.

"Otherwise, we have very few cuts—and even fewer burns. Splinters, however, are quite a common occurrence. I have very good splinter forceps; and if a splinter hasn't been tampered with, I can usually remove it—provided there is any portion of it above the surface. Those that I can't handle are referred to a doctor.

"When I first took over the dispensary, one of our teen-age boys who had stuck a splinter in his hand refused to come to me. 'That nurse is as blind as I am,' he told his supervisor; 'she can't get this splinter out!' The supervisor explained that I was thoroughly experienced, that I had all the necessary equipment, and that he was required to report all injuries. After a lengthy argument, he finally agreed to come in. The splinter proved to be a very superficial one, and I easily removed it and bandaged his finger. Later, he told several workshop people that he was sure I must be able to see; in fact, when the supervisor asked him if I had removed the splinter, he said, 'Well, she told me she did, but I think it was somebody else that did it.' Nevertheless, when the story got around, it helped to give people confidence in me—something quite important when I was new on the job."

In her nursing duties, Miss Hardy uses a number of unique instruments developed specially for blind people. They include: A Swiss-made mouth thermometer with a dial hand which registers the patient's temperature at the end of three minutes—the hand being controlled by a stem-like plunger which the nurse operates (the thermometer costs $18.75—and it takes six to eight months to get it to Switzerland and back for repairs.) Because of this thermometer's expense, she teaches her students to use the standard oral thermometer. They are taught to remove the thermometer from the patient's mouth and place it in a tissue. They then give it to the doctor or a member of the family who can read it for them.

Also included are: a manometer with a Braille dial (the patient has to hold the stethoscope while the nurse takes his blood pressure); an insulin syringe equipped with a gauge which the doctor can set at any required dosage; a step-on scale which registers the weight of her patients in Braille; a Braille diabetic food scale; and her indispensable Braille watch, her Braille writing tablet and stylus, and other equipment.

Another invaluable aid which Miss Hardy uses is her four-in-one measuring device, a single unit with a tablespoon on one end, and with the reverse side a half-tea-

In addition to first aid duties, Miss Hardy also teaches Braille. Here, she interrupts a class to treat a cut finger. She also talks to various groups on rehabilitation; last year she gave 102 speeches.

spoon measure; on the other end of the measuring device is a teaspoon and on the reverse side is a quarter teaspoon. All of Miss Hardy's medical records are kept in Braille, though she types the reports which go to the Lighthouse office. Everything in the way of medicines and drugs used in the dispensary carries a Braille label—which usually is four or five times the size of the ordinary handwritten prescription label.

As Lighthouse health instructor, Miss Hardy has encountered several problems that merit the consideration of all nurses.

"The number of diabetics among our blind people is increasing," she points out. "Most of them tell us that they weren't warned in time by their doctors that blindness could result from not properly following an insulin or a dietary regimen. The ones who are totally blind insist that they'd still have partial vision had they been warned of the danger before it was too late. Several now partially blind are working very hard to prevent total blindness—and they're all quite bitter at doctors and nurses generally; some, in fact, even vent their venom on me. So, if you ever have the opportunity to help a diabetic, be sure to tell him that one

way to prevent blindness is to take his insulin correctly and to watch his diet carefully.

"We have an awful lot of obesity among our people. Some of it is probably due to the sedentary home life they lead. Only about 5 per cent live alone and do their own work; the rest sit around while someone else in the family does the work. Many—because of limited finances—don't eat right: their diets run mainly to starchy foods, and this helps to explain why we have so many colds. Before we started to work on the diet problem, colds were responsible for a large part of our absenteeism—which used to run almost 50 per cent during the winter months."

In teaching home nursing, Miss Hardy had to develop certain safeguards and methods of her own. Most sightless mothers, she found, are afraid to take care of sick children and other members of the family; hence they have to be taught to do it without injury either to themselves or their patients. This means instruction in such rudimentary things as how to find the bed, how to offer a patient a glass of water without spilling it, how to avoid jabbing the patient in the eye, and how to follow the contours of the body in giving a bath. ("In a class of twelve," Miss Hardy recalls, "every member demonstrated the ability to bathe a patient perfectly—but all twelve left

the nose unwashed!") The Lighthouse nurse also makes good use of the Red Cross manual on home nursing which, as many R.N.'s know, is now available in Braille.

Another of her duties is teaching blind people to be more interested in their personal appearance. "Because they can't see, many think that appearance doesn't matter," Miss Hardy explains. "So, among other things, we have to teach girls how to keep their slips from showing beneath their skirts, how to comb their hair in a becoming style, and how to chose clothes that will improve their appearance. I frequently take them to neighborhood stores and teach them how to shop for clothes and other necessities. It's surprising how many of them have never been in a store alone before."

In addition to all this, the sightless R.N. also teaches various aspects of homemaking—orientation in the kitchen, cooking, washing, ironing, and so on. "The number who are afraid of the stove is quite astonishing," she says. "So we teach them how to light a gas oven safely, how to be sure the burner is turned on and the flame isn't too high. Many who have been burned using an iron have to learn to use protective metal devices which keep the iron upright on the board. Also, we teach our people how to use a washing machine and a dryer safely and properly."

In explaining the preparation of food, Miss Hardy has run into all kinds of odd difficulties. When, for

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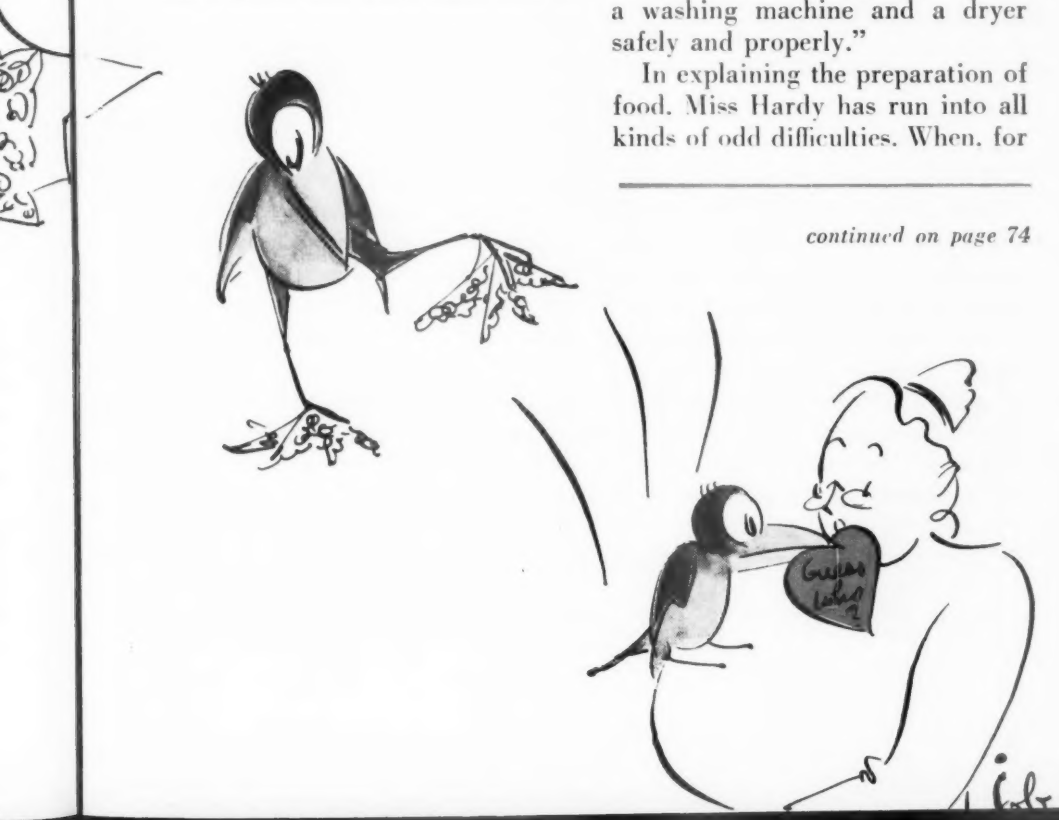

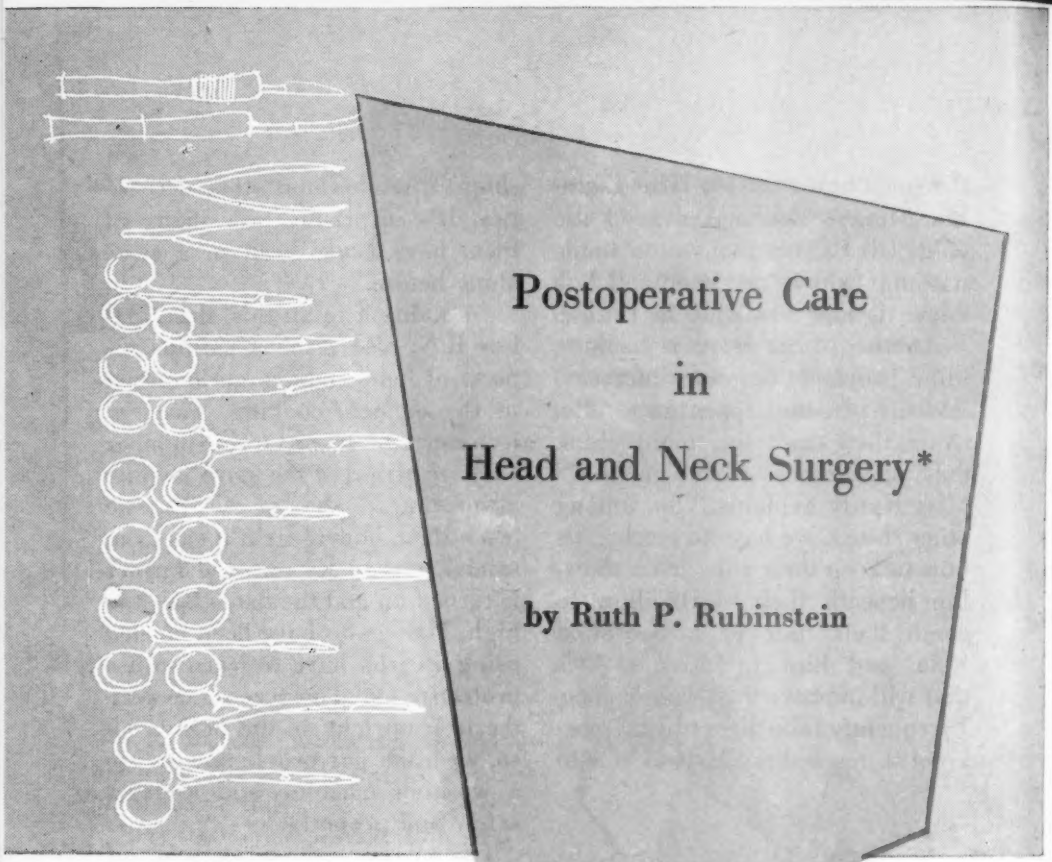

Postoperative Care in Head and Neck Surgery*

by Ruth P. Rubinstein

A nurse's first day on a head and neck surgery ward can be a traumatic occasion. Even those whose hospital experience has enabled them to adjust to other sights and odors require additional adjustment, when they first encounter a group of patients who have undergone radical surgery for malignancies of the head and neck. The sight of so much facial disfigurement, the maze of tracheostomy and nasal-feeding tubes, the odor of putrefaction, the patients' inability to control coughing, spitting, and drooling—any of these may bring on a feeling of aversion. Such a feeling must be quickly overcome; the nurse must realize that she can do the patient no good whatsoever until she faces his condition with the same equanimity that she would face other types of surgery.

This immediate adjustment to reality is emphasized here because it is indispensable to nursing care

*A supplement to the August 1956 article, "Radical Head and Neck Surgery" by Florence E. Brown, which covered the psychological aspects of this type of surgery.

in this particular area. The other psychological factors which affect such care can be better considered if we first review briefly the clinical aspects of head and neck cancer—the condition for which radical surgery is most frequently undertaken—as presented by Dr. Hayes Martin.*

Such surgery may involve one or more of four major areas: the mouth, the nasopharynx, the pharyngeal wall, and the larynx. Its purpose may be either curative or palliative: curative if the malignancy is in an early stage; palliative if the disease is so far advanced that the patient is in constant pain and has difficulty in swallowing or breathing.

Cancer of the mouth

This condition includes all malignant tumors originating in the mucous membranes of the oral cavity. Thus, the site of origin may be cheek, gum, tongue, palate, tonsil, or floor of the mouth.

Symptoms: Early subjective symptoms vary in character, depending upon the site of the primary lesion. The first warning sign may come with the discovery of a lump, a sore, or similar tissue condition which is detected by the tongue; or it may be brought to light through oral examination by a dentist or physician. Pain and tenderness, secondary symptoms, occur only when the ulcerated area is infected.

Treatment: Surgery, radiation, or both may be indicated.

Cancer of the nasopharynx and pharyngeal wall

The pharynx is a funnel-shaped tube that extends from the base of the skull down to the cricoid cartilage. Malignant tumors originating in the walls of this tube above the level of the soft palate are classed as cancer of the nasopharynx. Those originating below the soft palate and above the lower border of the cricoid cartilage are regarded as cancer of the pharyngeal wall.

Symptoms in Cancer of the Nasopharynx: Usually there is no advance warning of a primary growth in this area; the disease generally appears first in metastatic form—most frequently metastasizing to the cervical nodes, causing the patient to complain of lumps in the neck. In cases where the growth appears at the orifice of the eustachian tube, a local symptom occurs in the ear as unilateral deafness. Should the tumor become large and bulky internally, obstruction of breathing may result. Metastases to the base of the skull may cause (1) paralysis of the external rectus muscle; (2) diplopia; (3) exoph-

*These clinical aspects are covered fully in Dr. Hayes Martin's monograph, "Cancer of the Head and Neck," which is available in booklet form from the American Cancer Society, 521 West 57 Street, New York, N.Y.

thalmos; (4) perforation of the tympanic membrane.

Treatment: Cancer of the nasopharynx is usually treated by radiation rather than surgery—partly because of the difficulties involved in approaching the area surgically, and partly because this type of tumor generally has a sensitivity to radiation. Either external x-ray therapy or internal implantation of radium (or radon seeds) may be indicated.

Symptoms in Cancer of the Pharyngeal Wall: Slight pain when swallowing, and such other early symptoms as a slight throat irritation or discomfort, are apt to be so vague or indefinite that the patient doesn't seek medical advice until a lump in the neck appears. As the disease progresses, dysphagia occurs, together with a marked loss of weight. There is no evidence of hoarseness until the larynx becomes involved.

Treatment: Surgery—made possible only during the last decade—has been aided by such developments as the use of antibiotics and other new drugs, blood transfusion, new anesthesia techniques, and improvements in preoperative and postoperative care, as well as by advancements in surgical skill. Operation on the tumor involves removal of the pharynx. If the disease is not controlled, death may result from extensive metastases, local sepsis, and malnutrition.

Cancer of the larynx

The larynx extends from the tip of the epiglottis to the inferior margin of the cricoid cartilage. Malignancies originating in the vocal cords, the ventricles of the larynx, and the subglottic regions are classed as cancer of the intrinsic larynx. Those originating on the upper surface of the ventricular bands, the epiglottis, and in the postcricoid regions are regarded as cancer of the extrinsic larynx.

Symptoms: Hoarseness, persistent pain, discomfort in swallowing, and cervical metastases are signs.

Treatment: If the disease is not too far advanced, a partial or total laryngectomy may be attempted; otherwise, radiation is the only alternative.

Nursing care

Here, of course, we need consider only those procedures—all of them postoperative—which apply specifically to head and neck surgery: care of the tracheostomy tube, special attention to hemorrhaging possibilities, nasal feeding, and early ambulation.

Insertion of a tracheostomy tube is almost routine in surgery of this nature. Thus the nurse's immediate postoperative responsibility includes, as an absolute essential, the suctioning of this tube with a rubber catheter every fifteen minutes until the patient has completely

emerged from anesthesia. (Subsequent suctioning will be necessary as indicated.) Purpose of the procedure is to remove excess secretions, thus preventing atelectasis and/or plugging of the airway. As an added preventive, the patient must be encouraged to cough.

The tube's inner cannula should be removed and cleaned every hour or two during the immediate postoperative period, and at longer intervals during the succeeding days until the patient can handle it himself. Signs of tracheal obstruction should be constantly watched for: such signs include laborious breathing, cyanosis of the nail beds, stridor, and substernal retraction. To avoid formation of crusts and mucous plugs in the trachea, a constantly moist gauze dressing (4″x 4″), free from lint and cotton batting, is used over the tube.

Use of morphine and other narcotics for relief of pain is not advocated, inasmuch as these drugs depress respiration and inhibit coughing. Moreover, the patient's pain is usually less severe than in other forms of surgery because many nerves leading to the head and neck have been severed during the operation; hence, Empirin is often a preferred medication.

The nurse must be constantly alert—particularly during the first few postoperative days—for hemorrhaging from the wound, the tube, or the carotid artery. Precaution here cannot be overemphasized, for a patient may die from loss of blood in a matter of minutes.

Nasal feeding—be it a temporary or permanent requirement following head and neck surgery—is carried out by the nurse until she has taught the patient to manage it himself. Initially, however, the introduction of the feeding tube is handled by a member of the medical staff to make sure there are no obstructions or irregularities.

The diet usually consists of a special high caloric, high protein formula fortified with vitamins. Many of these patients, poorly nourished prior to hospitalization because of pain and difficulty in swallowing, require extra feedings at 5 A.M. and 9 P.M.

Early ambulation is recommended, with the patient briefly leaving his bed on the first evening after the operation or, at the latest, on the following day. The time out of bed is gradually lengthened as ambulation continues.

When the patient has recovered sufficiently, the nurse teaches him (1) how to aspirate secretions through his artificial airway; (2) how to care for the other aspects of his oral hygiene, including removal and cleaning of the inner tracheostomy cannula; and (3) how to insert his nasal feeding tube and feed himself. Carried out with the aid of a mirror, these are highly important—for the patient will

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never become independent until he has learned how to handle all three problems.

During this rehabilitation period, the nurse must still remain alert to the possibilities of tracheal obstruction and hemorrhaging. Moreover, she should teach the patient what to watch for, and how to signal for help if he needs it.

Psychological aspects

In preparing the patient psychologically for his operation, the surgeon endeavors to assure him that he will be able to live a relatively normal life after he has fully recovered; and when possible, he is given further assurance by persons who have undergone similar surgery and are now leading useful lives.

Despite all this, the immediate postoperative period is invariably a psychological shock to both the patient and his family. In our society—where a book is often judged by its cover—facial disfigurement creates far more worry than incisions in easily concealed areas. Add to this fact one's sudden inability to perform the simple function of eating in the normal way—plus the fear that future earning capacity has been jeopardized—and you have a highly apprehensive patient on your hands.

Extremely sensitive in the early postoperative period, the patient is quick to detect any indication of insecurity or distaste on the part of the nurse as she performs her duties. The nurse's emotional readjustment—dealt with at the outset of this article—must be accompanied by genuine skill and efficiency. A bumbling, incompetent nurse is almost certain to aggravate the patient's emotional state. If, on the other hand, the R.N. is both able and understanding, the patient's confidence in her will be of immeasurable value in his emotional and vocal rehabilitation. In the case of an inexperienced nurse, eagerness and willingness go a long way towards substituting for efficiency; in fact, the patient may even help such a nurse if he sees that she wants to help him.

Primary responsibility in bringing about a satisfactory emotional recovery rests with the nurse; but she must have the assistance and cooperation of the patient himself, his family, and other members of the health team.

The patient's family is likely to present problems of no small consequence. When close relatives make their first visit, the usual reaction is shock. Even though forewarned by the doctor, they are not quite prepared for what they see. Usually this initial visit is made before the patient has learned to handle his tracheostomy tube; if, therefore, he has a sudden coughing spell (as frequently happens), mucous, blood, pus, and other se-

cretions may be sprayed in all directions, and everybody becomes highly alarmed. Such a scene leaves its mark on the patient: he becomes greatly depressed because of his lack of control and the obvious reaction of his relatives.

Since repeated experiences of this nature may cause the patient to shun visitors, the nurse should do everything possible to prevent them. By keeping the patient extra clean when relatives are expected, by being close at hand when they arrive, by offering simple explanations, by answering questions, and by her own calm attitude, she can help to make visits pleasant, worthwhile, and of increasing benefit to the patient's morale.

Special considerations

Three other factors call for special consideration:

(1) Removal of the vocal cords during surgery has its psychological aftermath: the patient, unable to talk, and with only limited means of communication, tends to draw himself into a shell, as it were. Here, the nurse should see to it that he always has a slate handy, and should encourage him to communicate as much as possible. (If he is taught to cover the tracheostomy opening with his forefinger while he forms words with his lips, some voice sounds become audible.) Also, he should be reminded periodically that after he leaves the hospital he'll be able to attend a special school where he'll be taught to talk again.

(2) Postoperative edema, along with the heavy voluminous dressing, can cause a patient to feel wobbly, unsteady, and off balance. During early ambulation, the supporting arm of the nurse should provide the comforting reassurance that he needs.

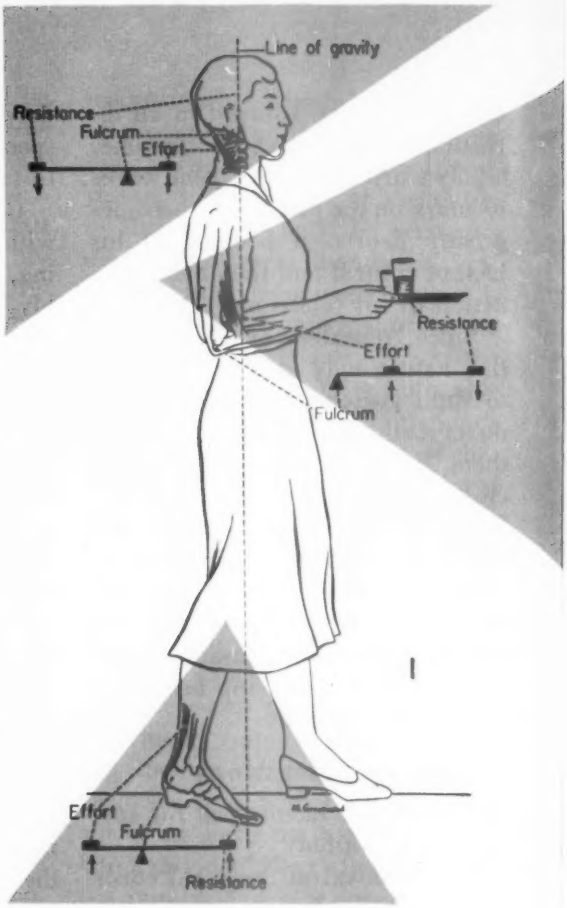
(3) The patient who has always had a hearty appetite is almost sure to feel depressed at the very thought of nasal-tube feeding. By teaching him to feed himself at the earliest possible moment, the nurse supplies the best kind of "pick-me-up" —for there's something psychologically uplifting in a patient's discovery that he is no longer entirely helpless but can now feed himself.

If financial worries appear to be retarding an individual's recovery, the alert nurse should be able to sense when the services of a social worker are indicated. Similarly, she may suggest the services of an occupational or recreational therapist when her patient's idleness begins to be boring or dispiriting. In these and other respects, she serves as the principal liaison between the patient and the various members of the health team.

First, last, and always, however, it's the confidence and reassurance she instills in the patient that will count most significantly in his rehabilitation. «»

How Simple Machines Help Nurses

by Maud Greenwood



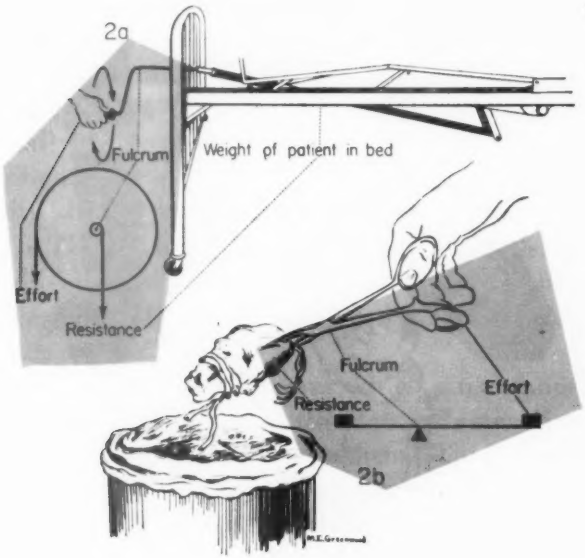
All of us use mechanical devices in this machine age and observe them in operation performing work. Machines may seem complicated, but the principles of physics, upon which all machines are based, are not really as complex as one might imagine. A machine is, in reality and by definition, a device consisting of two or more resistant parts serving to transmit and modify force and motion in doing work. The nurse's daily work is eased by such devices, both anatomical and mechanical.

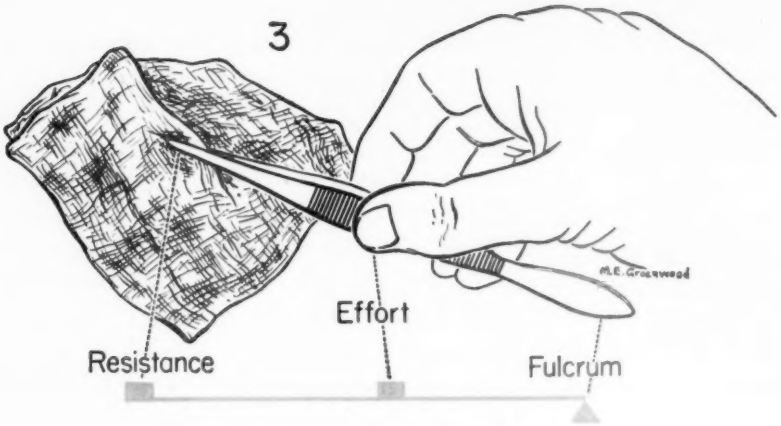
Most of the mechanical devices nurses use daily are based on three simple machines: the lever, the pulley, and the inclined plane. When force is put into any one of them, the result is an output of greater force, increased speed, or change in direc-

tion of motion. Examples of these three simple machines are used in any modern hospital to great advantage.

When you have two weights or forces rotating around a fixed axis like a seesaw, you have a lever. We use this machine constantly by the very motion of our bodies. In Figure 1, the fixed axis, known as the fulcrum, balances the two forces, resistance and effort, in the organic machine. The muscles act by means of levers supplied by the skeleton. Good posture with properly balanced forces will minimize fatigue, avoid injury, and lessen effort against the pull of gravity.

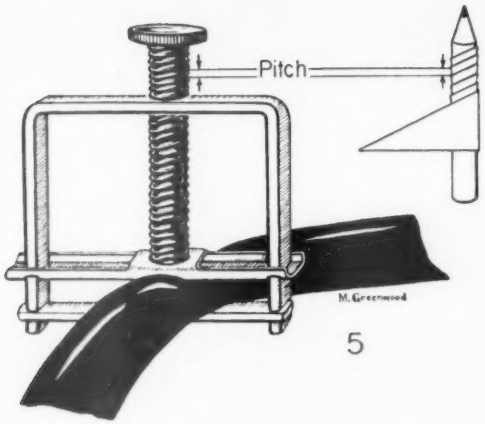
By means of its crank, the hospital bed, Figure 2a, enables the nurse to use a small force to lift a much greater resistance. The crank is a circular lever to which the nurse applies force. The principle involved states that the product of an applied force and its distance from the fulcrum is always equal to the resistance multiplied by its distance from the fixed axis, regardless of the location of the forces and their turning point. Thus, the large circumference of motion when the nurse turns the crank allows a small effort to be used to equal the small circumference multiplied by the large resistance. ⟶





←**Figure 2b is an example of a simple lever with the effort and resistance on opposite sides of the fulcrum. Because the effort is at a greater distance from the fulcrum than the resistance, less effort is required. This is why the holding force of the hemostat makes it a useful tool.**

When thumb forceps pick up a gauze square, Figure 3, the forces of action in levers are located on the same side of the



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fulcrum. Here, the effort applied increases the speed of motion of the resistance.

The second type of simple machine, the pulley, is shown in Figure 4a. In rehabilitating the paraplegic patient, the unaffected arms can exercise the legs by means of a pulley arrangement, thus preventing disuse atrophy. With the single fixed pulley, the effort is equal to the resistance.

With a movable pulley, on the other hand, the effort used can overcome twice as much resistance. In Figure 4b, the bilateral exerciser allows one pair of arms to exercise one or more pairs of paralyzed arms. Note that mechanical advantage increases with the number of ropes supporting the resistance over a combination of movable and fixed pulleys. Pulleys enable small forces to lift heavy weights far exceeding the effort applied.

The third simple machine, the inclined plane, is illustrated in Figure 5. The pitch, or distance between threads, on a screw is a simple inclined plane. You can illustrate this fact by wrapping a piece of paper, cut at a right triangle, around a pencil.

This machine is an upgrade over which a resistance is lifted by means of a little effort going through a greater distance, the circumference of the turning screw head. Thus, a small effort applied to the screw of a common clamp sustains a much greater force on the tubing.

Rural Nursing Adventure

by Jessie S. Neider

It happened at a 25-bed rural hospital in one of our western states. I had deliberately chosen to work there to learn what nursing is like in a small, isolated community. But I hadn't anticipated any such experience as this.

The time was 8:00 P.M. Visiting hours had just ended. Lights were popping on, evening medications were due, a patient in labor needed close watching, another—a young Indian woman—had just been admitted with what looked like an acute appendix . . . and I was the only R.N. on duty.

Answering the phone, I was startled and perplexed by the young doctor's briskly spoken order. "Give that acute appendix morphine, grains three-eighths, and atropine, grains one-one hundred fiftieth, I.V., stat.," he commanded, "and get her to the O.R. I'm going to have to do her tonight."

My momentary hesitation evidently annoyed him. "Didn't you catch?" he asked as my mind questioned the I.V. injection of narcotics by a nurse.

"Did you say intravenously?" I asked in a rather meek voice—

at the risk of sounding stupid.

Obviously, the question maddened him. Only recently out of the army, he was not accustomed to having his orders questioned.

"I did!" he barked, and the receiver clicked in my ear.

Assailed by doubts, I recalled my training in medical ethics. Only in extreme circumstances should a nurse question the authority of the attending physician. Yet it seemed to me very unfair that he should expect me to assume a responsibility that I felt belonged to him.

I had much to learn.

The young squaw—whose husband had remained at her bedside—was the first Indian patient I had ever encountered. Had I known then what I later learned (namely, that the Indian—usually a docile patient—sometimes reacts violently to certain drugs, and especially to those used in anesthesiology), I might have been spared a highly traumatic experience.

It so happened that she *did* remain quiet while I applied a tourniquet, swabbed her arm with alcohol, and inserted the needle into the vein. But as I released the tourni-

quet and slowly injected the drug, she began to fight like a demon—and to vomit excessively. The foul-smelling emesis gushed in every direction. Her husband, coming to my assistance, held her down while I doggedly hung onto the syringe.

When at last the ordeal was over and the needle withdrawn, she wasn't (as I had feared) dead; with her stomach emptied, she lay there completely relaxed and ready to take her anesthetic without difficulty.

I was still trembling when, a few moments later, in walked the young doctor. My unnerved state could hardly have escaped his notice. "Better not let a thing like that bother you," he told me. "If you stay around here long enough, you may have to do a major operation."

Fortunately, it never came to quite that. But I did stay around long enough to learn what a variety of problems the nurse must contend with in a small, isolated hospital.

My previous experience had been limited to large metropolitan ones where the nurse, merely by using the phone, could summon a doctor or consult her supervisor. Here, the only available doctors were two or three rural practitioners who were trying to spread their services over a large area; to reach any one of them might take, not a matter of minutes, but an hour or two—while a patient's life hung in the balance. Thus the nurse's first consideration here had to be the sustaining of life; and if some activities seemed fantastic and unethical to the newcomer, she presently (as I did) learned otherwise.

My reason for seeking this job had stemmed from a study I made in preparing my thesis for a master's degree. Certain findings had aroused my curiosity about nursing trends; and since the study had been made in an area of fair nursing supply, I was eager to learn if conditions elsewhere were similar.

A simple method sufficed in choosing this particular hospital. First, I perused the listed openings in professional journals to find a state that appeared to be (1) short of R.N.'s, and (2) paying very low salaries. Selecting one, I checked on its educational facilities—and found that it had but one school of nursing. Next—without making any preliminary contacts—I entered this state as a tourist; and

driving from community to community, I made numerous inquiries of residents about local medical-hospital facilities.

The availability of such facilities varied greatly, I found. Many of the larger towns—especially those in well-known tourist areas—had built fine new hospitals, and these had attracted fairly adequate numbers of doctors and nurses. In other communities, forty miles or more from the nearest hospital, the doctor-nurse supply was extremely limited.

Eventually, I found the above-referred-to hospital—an old, remodeled building whose every nook was being utilized, with little or no thought for the convenient location of service facilities. Employed as a staff nurse on the afternoon shift at $250 a month, I had two teen-age aides, trained on the job, as my only assistants. Although their training had been inadequate, they were, I soon found, resourceful. (Indeed, everyone engaged in nursing thereabouts proved to have that trait.)

At first I was appalled at the demands made upon the hospital's few professional nurses. As the only R.N. on the afternoon shift, I was soon functioning as a jack-of-all-trades. When the office staff quit work at 5 P.M., I took over admissions, discharges, and the telephone. In addition, I had to administer all medications, supervise the two aides, take care of all emergency cases (there were many of these), and—worst of all—assume full responsibility for the O.B. patients. This not only meant conducting labor right up to the last moment and assisting with the delivery but also (when the doctor failed to arrive in time) officiating.

Under such conditions, a state of emergency prevailed almost con-

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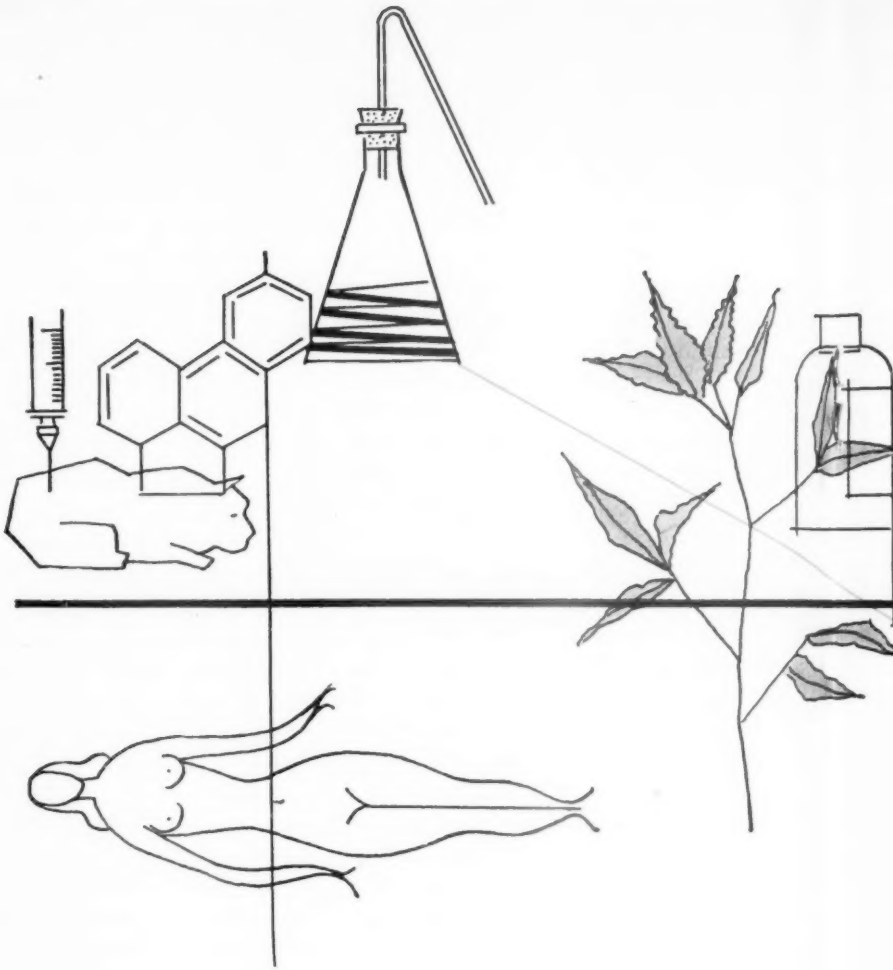
VALENTINE TO A HEART SPECIALIST

You really should return that kiss,
My heart is pounding, sorta;
I won't repulse you if you do,
Although I know aorta.

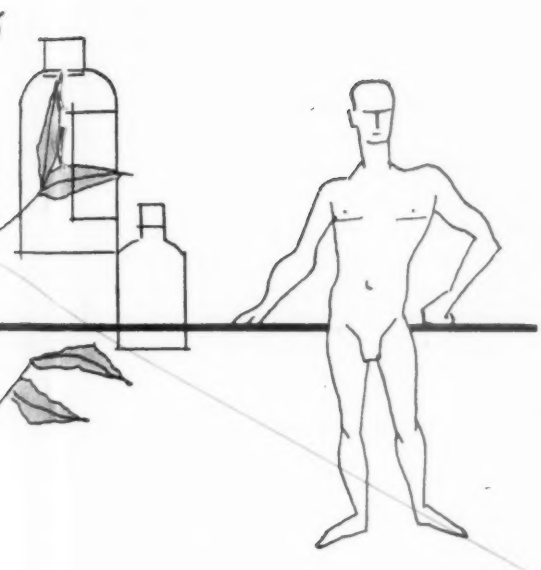
—MARGARET E. SINGLETON



The History and Scope of Pharmacology

This article is the first in a new series by Dr. Rodman in response to requests for a systematic review of the principles of pharmacology and therapeutics. Each article will deal with a major class of drugs; and the series will follow the format of Dr. Rodman's successful lecture course, offered by the Extension Division of Rutgers University, for nurses, chemists, and executives of the U.S. pharmaceutical industry.

The course endeavors to survey the various types of pharmacological agents with the purpose of explaining how drugs affect body functions in ways that may be ben-



by Morton J. Rodman, Ph.D.

eficial in the treatment of disease.

This introductory article, conveying a sense of the continuity of the timeless battle against disease and death, presents some of the problems that must be solved in bringing biological research on a new drug to a successful conclusion.—THE EDITORS.

Pharmacology, the study of drug action, is at once one of the youngest of the medical sciences and one of the oldest branches of man's knowledge. Few of us realize, when another drug discovery is announced, that the new agent represents a hard-won victory in man's endless war against the destructive forces of disease. Nor are we often aware of the months and years of scientific study that were probably required before the new drug could be marketed for medical use.

The story of pharmacotherapeutics, the use of drugs in the treatment of disease, had its beginnings in earliest antiquity. Primitive man probably first came upon potent chemicals quite by accident as he foraged for food among the plants of the field. And many savages must have sickened and died before our aboriginal ancestors began to differentiate between roots, berries, and barks that were safe o consume and those that were not.

Gradually, however, after much sad experience with poisonous plants, the survivors undoubtedly came to recognize that small quantities of certain substances could be useful in relieving pain and suffering. Through a slow system of trial and error, depending upon close observation of the way in which ailments responded to drug treatment, various peoples accumulated considerable information about the

healing properties of plants and other natural products.

Many of the medicines, discovered in this empirical manner by the ancient Egyptians, Hebrews, Arabs, and Greeks, are still in use today in one form or another. Opium, colchicum, and castor oil, for example, are mentioned in the famous Ebers Papyrus that dates from 1550 B.C. Cinchona, the quinine-containing antimalarial bark, was a standard fever remedy among the Indians of South America when the Spaniards conquered that continent in the sixteenth century; and North American Indians utilized the cathartic properties of cascara bark long before the coming of the white man.

Despite the effectiveness of a few such remedies handed down to us from the folklore of primitive peoples, most of the animal, vegetable, and mineral substances used traditionally in the treatment of various conditions were, in fact, quite worthless. As is still the case today in poorly controlled clinical studies, medicines that happened to be administered simultaneously were frequently credited with curative properties in illnesses which had actually cleared up spontaneously as the disease ran its course. The uncritical acceptance of such seeming successes resulted in the retention of countless innocuous drug combinations in medieval compendia of materia medica.

Late in the seventeenth century, however, a handful of pioneer experimenters began the tedious task of weeding out the few really useful drugs from the vast mass of relics and rubbish accumulated over the centuries. Much of the malodorous filth that had passed for medicine up to that time was indeed, eliminated from the pharmacopeias. Yet, truly significant advances in rational drug therapy occurred only after nineteenth-century developments in organic chemistry and experimental physiology made it possible to study the actions of pure chemical principles on living animals.

Pharmacodynamics

The isolation of morphine from crude opium, and of strychnine, quinine, and other alkaloids from various other plants stimulated the development of the new science of pharmacodynamics, the study of the reactions between chemical agents and living things. For the first time, it became possible to determine exactly how much of a drug or poison was needed to produce a particular result or to cause a toxic reaction. Even today, this is still the first step in the pharmacological appraisal of a new chemical.

In evaluating a newly synthesized chemical or a pure principle isolated from natural sources, the

pharmacologist's first task is the determination of its dose-response relationships. Working with several species of specially selected experimental animals, he tries to learn how much of the chemical is needed to bring about various desirable and toxic reactions.

One difficulty that must be faced and overcome is the fact that individual animals often vary widely in their ability to resist or tolerate drugs. No matter how carefully experimental animals are bred and selected for uniformity of strain, sex, age, and weight, some will react strongly and others weakly, to the action of a particular drug. To reduce the chance of error because of biological variation, it is necessary to give the drug to several groups of animals at different dose-levels, and then to evaluate the experimental data statistically.

When initial screening indicates that a chemical has pharmacological properties potentially useful in the treatment of some clinical condition, the drug's safety and effectiveness in several species may be compared with those of drugs that doctors are already using for the same purpose. If the experimental data indicates that the new drug

"WHY DON'T THEY FEED THEM INTRAVENOUSLY?"

has a favorable "Therapeutic Index"*, *i.e.*, that it is likely to be more potent and less toxic than other available agents, the pharmacologist clears it for clinical trial. But most chemicals subjected to such screening are discarded due to lack of effectiveness or undesirable reactions.

Disagreeable side effects

Often, too, drugs that seem safe enough in animals do not work out well when tried in human patients, who may react in ways that cannot be predicted in animal tests. Such side effects may occur in only a small proportion of patients but are often so dangerous that the drug must be discarded.

For example the oral antidiabetic drug, carbutamide (BZ-55), was recently withdrawn by the manufacturer after extensive clinical trials showed that a small but significant minority of diabetics suffered ill effects while under the medication.

Occasionally, however, a drug may be so specific for a certain condition that doctors go on using it despite disagreeable side effects. Digitalis, for example, though it frequently causes nausea and vomiting, is still the drug of choice in congestive heart failure, and colchicine continues to be employed against acute attacks of gout in spite of the severe diarrhea it often causes in effective doses.

Drugs likely to cause reactions involving the bone marrow, liver, and skin are usually considered unsafe for routine use. Yet some such drugs and others with very narrow safety margins, may have to be used for want of anything better. For example, few of the anticonvulsant drugs introduced in recent years for the prevention of epileptic seizures are entirely free of annoying, or even potentially fatal ill effects. But because these drugs reduce the number and severity of seizures in many epileptics, some, who formerly would have been institutionalized as completely incapacitated, are now living normal, useful lives. Little wonder, then, that neurologists prescribe these drugs for prolonged daily use despite their potential danger.

Clinical criteria

The clinical criterion of whether the risk of using such a drug is warranted is the seriousness of the patient's condition. Thus doctors continue to use the antibiotic, chloramphenicol (Chloromycetin); despite several reports in 1952 and 1953 of associated blood

*The scientist states the safety of a new drug as a ratio between the LD_{50}, the amount that kills half the test animals, and the ED_{50}, the dose that gives some desired response in half the group; the higher this "therapeutic index" number (obtained by dividing the LD_{50} by the ED_{50}), the greater the drug's margin of safety.

dyscrasias, its use continues because it is often life-saving where other antibacterials are ineffective. On the other hand, the analgesic-antipyretic agent, aminopyrine, has been prescribed infrequently in this country since it was shown capable of causing agranulocytosis, a severe and frequently fatal reduction in white blood cells: physicians are not willing to take the chance of producing a dangerous depression of bone marrow function, even in a small fraction of patients, merely to relieve a headache or reduce a fever, especially when such a comparatively safe drug as aspirin is available.

Tests and checks

When a doctor decides to use a potentially dangerous drug he must be able to recognize the first signs of its ill effects to take prompt action to prevent irreversible tissue damage. Frequent physical examinations, including blood and bone marrow studies, liver function tests, and other checks are required when a patient is taking a hazardous drug for prolonged periods. Similarly, such potent drugs as curare, emetine, and others in which the effective and toxic-dose ranges overlap, should be used only with the greatest caution. Curare compounds, for example, should be employed only by anesthesiologists and other M.D.s familiar with the first signs of its pharmacological and toxic effects; and those administering such compounds should be equipped with apparatus for immediate mechanical resuscitation if respiration begins to fail.

When a drug fails

Lack of clinical effectiveness keeps some drugs from reaching the market despite initially favorable predictions made from laboratory reports. Such disappointments are often attributed to the ways in which human metabolism differs from that of other species in handling a chemical. Thus, enzyme systems present in human tissues may convert the chemical into inactive metabolic fragments so rapidly that it cannot attain a high enough concentration at the site of action to produce the expected effect. In the same way, differences in the rate of absorption of a drug may account for its effectiveness in some species and its failure when administered to man.

On the other hand, the reverse sometimes happens: drugs that have been discarded after poor results in laboratory tests have later proved effective in treatment of human diseases. The sulfonamide, Prontosil, stayed on the shelf for almost three decades after screen-

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SOCIAL SECURITY:

Coverage of Military and Ex-military Nurses

by Al Graham

FOREWORD: *Military nurse officers, like all other members of the armed forces, were recently accorded Social Security coverage (beginning January 1) on the same general basis as the majority of civilians. Most questions about nurse-officer participation are therefore answered in R.N.'s "Q. and A. on Social Security Changes" (November 1956) which explained in detail how the overall program now functions. In some instances, however, the benefits of military and ex-military nurses may be affected by "wage credits" allowed them by previous legislation. For this reason—and because military retirement pay is a related consideration for career-minded nurse officers—the following supplementary information is indicated.*

—THE EDITORS.

Q. What are wage credits?

If you served in the armed forces between September 15, 1940, and January 1, 1957, you are entitled to a Social Security wage credit of $160 for each month (or fraction thereof) of active duty—provided (a) your discharge or release was under conditions other than dishonorable, and (b) you either had as much as ninety days of service totally or were discharged or released because of a service-connected injury or disability. These wage credits are gratuitous inasmuch as military personnel were not contributory participants in the Social Security program during that period.

Q. Does this provision cover former nurse officers?

Yes—and regardless of pay or rank while in service.

Q. How are military wage credits applied in figuring my Social Security retirement benefit?

They count the same as monthly earnings in civilian employment. When you apply

for your Social Security on reaching retirement age, the amount you receive monthly will be based on your average monthly earnings (including military wage credits) over a period of years.

Q. If I make Army nursing my lifetime career and remain in service long enough to qualify for military retirement pay, will I also be eligible for a monthly Social Security benefit?

Yes; but in computing an individual's Social Security benefit, gratuitous wage credits may not be granted if eligibility for military retirement pay has been based on any service during the wage-credit years. This condition, however, has been modified by subdividing the wage-credit span into two separate (though consecutive) periods: (1) September 16, 1940, through July 24, 1947, and (2) July 25, 1947 through December 31, 1956. Thus, an individual might qualify for wage credits in one period and for military retirement pay in the other. Further modification provides that individuals on active service on and after January 1, 1957, are to be granted wage credits for the period after 1950 and before 1957, even though this six-year span be used in qualifying for military retirement pay.

Q. Will my four years as an Army nurse (1942-45 inclusive) be counted as sixteen quarters of Social Security coverage?

Yes. Every calendar quarter (or fraction thereof) of active service between September 15, 1940, and January 1, 1957, counts as a quarter of coverage, even though the individual was not then a contributory participant in the Social Security program. Once a quarter of coverage is earned, it can never be taken away. Bear in mind, however, that quarters are used only in determining one's *eligibility* for benefits—not in figuring the *amount* of the benefit.

Q. How many quarters of coverage does a military nurse require?

As in civilian employment, that depends entirely upon date of birth. A female R.N. born in

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Visiting Nurse

by Vivian Sheehan

The woman stared fiercely at her from under a dark brow. Suddenly the baby stiffened and let out a short gasp.

It was a hot day in July, and I had shoved my blue felt hat on the back of my head to catch any stray breeze. My uniform was plastered to my wet back and my oxfords were hot and heavy on my burning feet. The black leather bag I carried seemed to weigh much more than its alleged twenty-five pounds as I walked past tenement buildings and sagging dwellings. Everywhere there was neglect, and the smell of the stockyards and the melting tar.

I turned a corner and came upon a group of half-naked kids splashing under an open hydrant. When I passed they called, "Hi, nurse."

One asked if I'd come to see the new baby.

When I said, "Yes," he smiled and said, "I'll take ya there."

Some of his friends came along, whispering, and giggling, and pushing each other trying to walk beside me. We went along a narrow passageway between two tenements. There was a small un-

painted frame house in the rear.

My escorts, indicating the house, ran off.

Scuffing steps answered my knock on the sagging door. The door opened an unfriendly two inches. All I could see was a dim figure and piercing black eyes.

"I am the visiting nurse. I came to take care of the new baby." The door opened and I followed the woman into a large, cool kitchen. I was continually being surprised in this work. Often the most rundown exterior housed the cleanest home and family.

The woman watched me unsmilingly as I placed my bag on a newspaper on a kitchen chair. She had wiry black hair with wide patches of gray at the sides. There were two deep vertical furrows between her eyes. She had a large mouth which drooped at the corners, and a straight, long nose. Small gold loops hung from her pierced ears. Her thin body was covered by a black cotton dress.

While I removed my cuffs and rolled up my sleeves, the new mother called from the bedroom and I went in. She was lying in a double bed covered by a cerise satin spread. On the colorful dresser were bottles of wine in many shapes and colors. The room was spotlessly clean and had a festive air about it. The birth of a son was cause for celebration.

The mother, her straight black hair parted in the middle and hanging over her shoulders in long thick braids, wore a yellow silk nightgown. She explained to me that her mother was unable to understand or speak English, but she was sure everything was ready for my visit. With a smile, she nodded to a white wicker bassinet in which the baby lay sleeping.

I went back to the kitchen, scrubbed up, put on a white apron, and prepared to bathe the baby. I took from my bag two thermometers, cotton, a bottle of alcohol, a bottle of oil, and a cord dressing. In the meantime, the grandmother brought in enough clean clothes for three babies. I chose a wrapper, shirt, diaper, and band. When I looked up to thank her, she was shaking her head. I was sure after I left she would add many more layers so that the baby would not catch cold.

I went in to get the little fellow. He had a few wisps of black hair on top of his head and big deep blue eyes.

"He's lovely," I said, cuddling him in my arms.

He started to cry. At the first sound the grandmother came running into the room and followed me out to the kitchen. All during the bath, I felt her eyes on me as she watched every move I made. She never relaxed until I had the baby dressed and in his crib. [MORE]

Then I bathed the mother. Ordinary household articles were used and they served well. A sterilized mason jar acted as a pitcher, and newspapers substituted for a rubber sheet.

When I finished, I wrote down on a slip of paper the temperatures of the baby and the mother, the care given, and the condition of each one. I pinned it on the lace curtain in the bedroom for the doctor. During the bath the mother told me she was a policyholder in an insurance company which provided nursing care. I copied the policy number for our records.

"Please have a glass of wine in honor of the baby," she said, after thanking me.

"I am sorry," I answered, "but we are not allowed to drink while out on visits. However, I do wish the baby and you health and much happiness."

This apparently satisfied her and I left.

That evening I called the doctor for orders. I knew him well. He laughed when he found out I had visited his case. "The only order I have for you, young lady, is to watch your step. If anything goes wrong with that baby you'll find a knife in your back."

Two days later, I returned to the little house behind the tene-

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How to get Health

Organizations that distribute health education material (leaflets, films, radio scripts, exhibits, and the like) say that many of the requests they receive could be filled more intelligently if those asking for such materials would be more explicit in stating exactly what is wanted and how it is to be used: *i.e.*, when, where, why, by whom, and for what specific purpose. "Remember," says a recent announcement, "that if we are working in the dark we probably will not hit the bull's-eye."

In a directive to nurses and others who write in for sources of such ready-made materials, the National Publicity Council for Health and Welfare Services, Inc. (257 Fourth Avenue, New York 10, N.Y.), offers a brief summary of the kind of information "which any agency would probably need before it could fill requests satisfactorily." The council's suggestions (condensed) are as follows:

If you want a leaflet

It is not enough to request (for example) "a leaflet on rheumatic

Education Material

fever." You might get one addressed to mothers, explaining home care; yet perhaps what you really wanted was an appeal for more hospital beds. Tell how you are going to use the leaflet. What should it emphasize: prevention, early diagnosis, treatment, or community action? To whom will it be distributed? How many copies will you need? Have you any special requirement as to size, cost, etc.?

If you want a radio program

Do you want a script or a transcription? A talk, interview, panel discussion, or dramatization? If you want a dramatic script, must it be suitable for amateur production? Do you want a five-minute program, or a fifteen- or thirty-minute one? What main points should it cover? Will it be part of a series? If so, what series characteristics should it match? Are you willing to pay a small fee which some script agencies charge?

If you want a film

Do you want to buy or rent it? When, where, and to whom will it be shown? Is your projector 16 mm. or 35 mm? Is it wired for sound or not? How many minutes do you want the film to run? Can you use a film on a related subject if what you want isn't available?

If you want an exhibit

Who will see it: doctors, nurses, industrial workers, school children, or the general public? Will it be shown by itself or as part of an exposition? How much space is available? What kind of space: a wall, table top, or store window? What single message should the exhibit convey? If what you want isn't available, can you build an exhibit based on suggestions we send? How much can you spend in so doing? Can you count on the services of an artist, a photographer, or both?

Whatever you want

You will get much better results if, in requesting health education material, you explain fully the purpose you have in mind and the plans you have made to accomplish your aim. »«

Coffee and Doughnuts Hospital

by Richard C. Davids

THREE blasts of the fire whistle was the signal. All Eastland stopped to wonder: Who was the first patient at the spanking new hospital?

Phone calls flooded the central office, asking: "Who made it?"

It was an 8½-pound Texan, who brought his mother along. He made the front page of the local paper that night.

Maybe that wouldn't make news in your town. But in Eastland, Tex. (pop. 3,626), just about every man, woman, and child—whether black, white, or brown, whether from the right or wrong side of the tracks—had an investment in that hospital.

Eastland built it without a cent of government aid; built it after hours—from 6:30 P.M. till midnight—with coffee and doughnuts for pay.

Every week night, thirty to fifty men went up to Hospital Hill to dig the foundation ditch and basement. Lawyers, ministers, merchants, and a young doctor dug night after night. Now and then they'd stop to show off their blisters, or to admire the calluses of others better acquainted with pick and shovel.

The women were there, too, with coffee by the pailful and dishpans of doughnuts, along with words of praise that somehow made every night a celebration.

One woman was timekeeper, keeping strict account of every hour. Next day the newspaper carried the names of men and women who served the night before. Twice a week, Mrs. Sam Butler did a radio broadcast from Hospital Hill. So it went, long after the novelty wore off.

Those who couldn't work made other contributions. Mrs. J. M. Alford, who takes in washing, started it with $10. Others followed. One

man gave a carload of cement; another, most of the sand and gravel.

Distant jobbers wrote, "Come and get it; we'll waive all profits." A Dallas industrialist told his manager, "Give those folks all the cement blocks they need, and send one of our engineers to help lay them."

Short 12,000 feet of steel, it seemed once that work would have to stop. Next morning, trucks were unloading it on the hill!

In the black market, wire was like gold. With 8,000 feet needed for the nurses' call system, and 2,000 feet for the public address system, letters went out. Back came the answer: "We'll supply what we can, and here is a list of plugs, switches, etc., we want to donate."

Cable, too, was found when it didn't seem to exist: and its total cost was buried in the speedometers and telephone bills of a dozen people.

Plumbers, electricians worked exhausting hours, with coffee and companionship to keep them awake.

In seven hours, 100 cubic yards of concrete were poured. Except for the man at the mixer, not a skilled workman helped with this feat. One freezing night, thirty-five men put on 4,000 square feet of roof decking in a 20-mile-an-hour north wind. You can't pay men for that. Except with doughnuts and coffee.

So the job got done, after nine solid months. Months of laughter, horseplay, and stories already grown to legends.

The 20-bed hospital, with only $11,814 spent on labor, cost totally $36,112. That's $4.51 a square foot—about a third the usual cost. To help run it, there's a $3-a-year assessment on water meters—but it's voluntary only.

After the hospital was approved by the American Medical Association, and by state and national hospital associations, young doctors came to look the town over. Two decided to settle.

On June 8, 1953, came the grand opening, attended by 2,000. Men and women with a hundred or more hours to their credit got certificates (and a vote each in the management).

At the climactic moment, who cut the ribbon that opened the hospital? Mrs. Alford ,the wash lady, looking flustered, warm, and oh so proud.

On a sundial in front of the hospital is a plaque that dedicates the building to men from Eastland County who gave their lives for their country. But the building stands as a monument to a community which laid aside social, racial, and religious differences, banded together to erect a structure exemplifying the American spirit of community living. «»

Condensed, with permission, from *Town Journal*, June 1956.

NEWS

Cancer Over-Stressed? Public Doesn't Think So

Most cancer patients and their families do not fear the disease, want to know more about it, and think cancer education saves lives. This was revealed in a survey of 560 persons on their attitudes toward cancer education conducted by the University of Wisconsin Tumor Clinic.

Persons most affected by cancer —the patients themselves and their families—feel that cancer education is not being over-stressed and is not resulting in "cancerphobia." Said Drs. Robert Samp and Anthony Curreri, who conducted the study: "The cancer educational programs rather seem to be stimulating an awareness, an alertness or consciousness in maintaining good health."

The survey also revealed:

¶ Fully 85 per cent of those interviewed felt that they knew more about cancer than did their parents, despite the fact that the vast majority considered the present cancer education program "not enough" or "just right." Only twenty persons thought there was too much education.

¶ Almost all those questioned agreed that fear of cancer was reduced by explanations offered in educational programs, and that such education aided early diagnosis.

¶ More than one-third felt that cancer education did not reach the people who need it most. These persons commented that rural areas and small communities did not receive enough education. Several men commented that cancer education seemed to be directly more toward women.

'Homestead' System May Correct Hospital Misuse

Plans are underway in New York City for the establishment of "homestead" units near municipal hospitals for people who no longer require hospital treatment. The need for such facilities became apparent when an eighteen-month study revealed that one of each five patients in the city's hospitals no longer needs hospital care—but remains there because he has nowhere else to go.

The system could save the city nearly $5 million a year and greatly relieve shortages of hospital personnel and facilities. Over 2,200 of

New York City's 10,000 municipal hospital beds are occupied by patients who no longer need active medical care. And the accumulation shows signs of ultimately taking over all beds; 1,200 similar patients are expected in the next six months.

First homestead will be located near Goldwater Memorial Hospital, where unused buildings will be converted to the new use without substantial investment. Transferred to homesteads will be patients with no homes or relatives and those who are too disabled to return to a home environment. Generally, these patients were once victims of nervous disorders, afflictions of heart and blood systems, and arthritis.

Prepaid Social Work?

The day may come when hospital social workers move out of the charity wards and into the field of private and semi-private medical care. That's the prediction of Dr. George Baehr, president and medical director of the Health Insurance Plan of Greater New York. He says social work should move with the trend and be an integral part of medical care, both inside and outside the hospital, and that it should look ahead to the time when it will be concerned with persons of all economic levels. Social work, he adds, may develop under prepaid plans—similar to medical care plans—in the future.

Latest Data Shows One R.N. For Every 386 Americans

Nursing is still a good distance away from its reasonable goal of one professional nurse for every 333 people in the United States. Latest figures indicate that 28,000 more professional nurses are at work in the country now than there were two years ago. But an additional 70,000 are needed.

How many R.N.s are currently employed? According to the American Nurses' Association, the National League for Nursing, and the U.S. Public Health Service, the total is 430,000—of which at least 42,000 are working on a part-time basis. This compares with 401,600 employed in January. 1954.

The 3 per cent increase in the ratio of professional nurses to population since 1954 is better than

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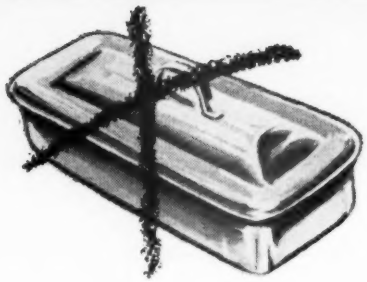

For Patient Protection

Your PETROLATUM GAUZE MUST NOW BE U.S.P.

The U.S. Pharmacopeia – Revision XV[1] – lays down the following specifications for making petrolatum gauze:

1. Gauze and petrolatum must be sterilized separately:–
   a) Dry Gauze to be sterilized in an autoclave at 121° C. (250° F.) in an atmosphere of steam for 30 minutes.
   b) Petrolatum to be oven-heated to 170° C. (338° F.), then maintained at 165°-170° C. (329°-338° F.) for two hours.
2. Components must be combined aseptically.
3. The finished product must meet U.S.P. sterility tests[2].
4. Each petrolatum gauze unit must be packaged individually to maintain sterility.

(1) U.S.P. XV, pp 304-305. (2) U.S.P. XV, pp 841-846.

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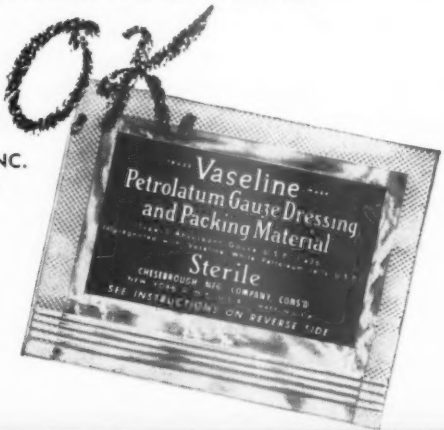

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ment buildings. The first thing the mother said was, "The nurse who took care of us yesterday had some wine."

I started bathing the baby, with the grandmother, still unsmiling, watching me intently. Suddenly, he stiffened and let out a short muffled gasp. His diaphragm was immobile. He turned cyanotic—the dread mucous plug! I quickly lifted him from the pillow and held him head down, carefully extending his chin to make a straight passageway. I gently compressed his chest, trying to force the mucus from the trachea. Please, God, make him breathe, I prayed! Suddenly, the plug was dislodged. He let out a cry and with it air came rushing into his lungs. He cried lustily and turned a healthy pink. I held him close, comforting both of us, for he had been frightened, too. As I put him back on the pillow, I looked up in time to see the grandmother staring fiercely at me from under a dark brow, her hand tight around a kitchen knife on the table. The doctor's remark came back to me and I shivered.

When I was readying to leave, the mother offered me wine again. This time I did not refuse. Then, saying, "Goodbye. See you tomorrow," a little too gaily, probably, I assembled my supplies. As the grandmother let me out the door, I detected a faint smile. «»

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example, she attempted to teach a 19-year-old girl to fry eggs, the girl—who didn't realize that an egg is fragile and who had never before handled one—ruined a whole dozen before the nurse could show her how to crack the shell successfully. This experience, together with similar ones in acquainting blind people with the use of kitchen utensils (many trainees don't even know what a paring knife is), soon convinced Miss Hardy how important it is that children blinded early in life be brought up to be self-reliant. "In a great many cases," she points out, "over-protectiveness on the part of parents is to blame for the helplessness of such children when they reach adulthood."

Her statement goes a long way to explain why the Lighthouse places such emphasis on the home training phase of its program. This project is carried out by Lighthouse instructors who visit homes throughout the area to work directly with parents, other relatives, and neighbors in helping newly blinded youngsters, from infancy on up, to acquire the fundamental self-confidence they will need throughout a sightless life. Postural bad habits and other such "blindisms" (as they are called) are corrected before they can become ingrained. Thus, by the time these tiny tots reach nursery-school age, they frequently are better adjusted than adults whose vision is only partially impaired.

"You should see them during play hours at the nursery school," says Miss Hardy. "While their mothers sit timidly by biting their fingernails, the children ride tricycles, roller skate, and climb trapeze bars as capably as sighted children. We take them to visit the fire station, and they know what a fire truck looks like, and a fireman's cap, too. They go to the zoo, where they learn about various animals—and the ones they can't touch there, we have in figurine form for them to examine in the nursery. They know which cars they like best—Cadillacs, usually! It's really amazing how well informed they are."

Aside from her nursing and teaching duties, Miss Hardy serves the Lighthouse in still another capacity—that of public relations representative. As such, she frequently addresses meetings of local clubs and civic organizations, and does considerable liaison work with other nursery schools whose instructors are interested in the Lighthouse child-training program. She is also active in various nursing groups—especially in the Houston branch of the American Association of Industrial Nurses. Last year, she attended and addressed the AAIN's national convention in Philadelphia, and her vivid description of her work at the Lighthouse was an outstanding feature of the five-day program. [MORE]

Pfizer drug notes

new MODERIL*

BRAND OF RESCINNAMINE

a new alkaloid of rauwolfia

for the treatment of hypertension and tension

2-22-57 Ward C
Bed 32
John Doe
Moderil
0.5 mg.
Bid - PC

History Although *Rauwolfia serpentina* remained unappreciated in the Western world until the last two decades, in India it had been used for centuries for "all" the ills of men. This wild shrub was named after a 16th century German botanist, Leonhard Rauwolf. The only potent alkaloid isolated from the whole root preparation until recently was reserpine. Rescinnamine (Moderil) is a newly isolated alkaloid and, like other rauwolfia drugs, acts by central depression of the sympathetic nervous system.

Advantages Moderil is a better tolerated antihypertensive tranquilizing agent than earlier rauwolfia preparations; side effects are less frequent and less pronounced. It is used in (1) labile essential hypertension; (2) in combination with more potent hypotensive drugs in less labile hypertension; and (3) for its tranquilizing effect in anxiety states in normotensive as well as hypertensive patients.

Nursing notes Side effects with Moderil are relatively infrequent and generally mild. Because of its sedative action, a few patients may become drowsy during the first few days of therapy but this effect usually disappears; another transient reaction may be nasal stuffiness. An occasional reaction is increased frequency of defecation, but this is considered helpful in the usually constipated hypertensive patient. The doctor prescribes Moderil to be taken after meals to avoid any possible gastric discomfort. Provided in oval, scored tablets in two dosages: 0.25 mg., yellow colored; 0.5 mg., salmon colored. No special storage required.

℞

Moderil
0.25 mg.

*Trademark

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(Parts of that talk are incorporated in this article.)

Miss Hardy has written a number of informative articles on blindness for professional journals and other publications. In these, as well as in her lectures, she has described from her own experience the many adjustments—both mental and physical—with which the newly blinded adult is faced.

"Contrary to general belief," she says, "your other senses don't suddenly become more acute when you lose your vision. You have to learn to use these other senses more intensively. In my own case, my taste vanished completely at first, and it was almost two years before I could tell what I was eating. Similarly, my sense of hearing, which had always been acute, became very much impaired; all sounds seemed bundled up together in my head, whirling around in such a way that I couldn't distinguish between one kind of noise and another. Many other blind people have told me they've experienced these same sensations.

"Another thing: my sense of balance was greatly upset. I soon found out that there's a lot of difference between the way a blind person must walk and the way a sighted person does. Here, of course, a good sense of direction is very important; and since I didn't have one, I've had to develop that, too.

"Like almost all of our Lighthouse people, I travel the streets of Houston alone. To a large de-

gree, we depend upon our sense of hearing to detect various sounds in the air currents—and that has both its advantages and disadvantages. On a windy day, for example, I can't tell when the traffic changes, so I have to depend upon someone to tell me when it's safe to cross the street. Most of us use a cane—though some prefer a dog, feeling that a dog offers more security and is a better means of getting the public to cooperate. My cane is strictly a feeler—a finder. By swinging it rhythmically from right to left in front of me as I walk, I protect first one foot, then the other. We've had very few street accidents among our Lighthouse people—and those have been limited wholly to persons with partial vision who depend too heavily upon their weakened sight to get them across busy streets.

"Almost always I can tell whether I'm in a large room or a small one, whether it's lighted or dark, and whether it's sparsely or extensively furnished. I'm still not a very good typist—but that's because I learned typing the wrong way before I was blinded; lately, however, I've improved somewhat in this regard."

Modest about her own accomplishments, Miss Hardy is extremely enthusiastic about every phase of the Lighthouse program—realizing from her own experience that learning to do for one's self is an all-important matter for the newly blind.

"I have a wonderful family and

wonderful friends," she says, "but nobody wanted me to do anything for myself. It's pretty discouraging to feel that you have to depend on other people for everything. Yet, that's what happens to many blind persons. They're waited on so much that they just don't fight. That's why you sometimes hear it said that blind people are lazy. I don't think they are. Usually, their ambition has been undermined by hearing their families say 'Let me do it for you' too many times. Actually, the whole household would be better off if the blind person had the chance to do for himself when he wants to.

"Blindness, in my opinion, is the least handicapping of all the so-called handicaps. Proof of this is evident among our Lighthouse participants: a great many of them are not only self-supporting but can do practically all of the things they could do before they were blinded."

Miss Hardy, herself, is probably the best example of that! «»

[This article contains excerpts from a talk given by Miss Hardy at the Fourteenth Annual Meeting of the American Association of Industrial Nurses, Inc., in Philadelphia last spring.]

Pick-of-the-crop Apples

Another reason why you can recommend Beech-Nut with confidence

Beech-Nut apples are the pick of the crop from the finest orchards. So perfect they can be cooked with the red skins on them so that precious vitamins directly beneath the skin are preserved. It's with good reason doctors recommend Beech-Nut confidently.

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Trust Beech-Nut...
carefulest baby feeders
in the world

continued from page 71

anticipated on the basis of previous estimates. Main reasons: more married nurses are returning to the profession and there's been an increase in the number of part-time employees.

In January 1954, there were 251 professional nurses per 100,000 population. This year there are 259.

Hospitals Send Nurse On Recruitment Tour

A registered nurse with experience in personnel relations has embarked on a month-long tour of the United States to recruit personnel for hospitals in California.

Vivian L. Hammon will visit thirteen colleges, some of them on the Atlantic Coast, in an attempt to interest seniors and graduate students in employment on health teams in San Diego County.

"This is the first plan of its kind in the United States," said Richard L. Johnston, president of the Hospital Council of the county, "where all hospitals of an area cooperated in solving their common problem of personnel shortage." The shortage in California has come about because of the area's tremendous population increase in recent years.

Miss Hammon's trip is sponsored by a Personnel Recruitment Committee, which includes doctors and hospital administrators and has the suport of seventeen hospitals in the San Diego area.

Duke Hospital Forms Intensive Nursing Unit

To help fill the gap between standard nursing service and special duty nursing, a new 14-bed intensive nursing unit for the care of the seriously ill was opened recently at Duke Hospital, Durham, North Carolina.

The new unit will be a partial answer to the shortage of special duty and practical nurses in Durham, according to F. Ross Porter, hospital superintendent. It will also provide nursing care for patients who require extra attention but do not need 'round-the-clock special duty nurses.

However, the new unit is "not intended to replace special duty nursing for those who need it," Porter emphasizes.

One nursing staff worker will be provided for every two and one-fourth patients as compared with one nurse per patient in the case of special duty nursing. Besides enabling Duke Hospital to concentrate some of its most severely ill patients in one area, the unit offers another stage of intensive care beyond the recovery room for surgical patients.

Survey of Iowa Office R.N.s

What are the duties of an office nurse? And how much does she receive for her services? A recent poll (by the Iowa Medical Society) of 174 R.N.s sought answers to these and similar questions. The findings:

¶ One R.N. respondent out of five actually makes home visits for her doctor-employer. Some 15 per cent do surgical scrub; and nearly as many make hospital visits.

¶ Virtually all the nurses polled assist in office surgery, as well as give injections and minor treatments.

¶ As for nonmedical duties, almost half the girls act as occasional receptionists; and nearly as many do occasional bookkeeping, correspondence, and housekeeping. But only one out of about four does this sort of thing regularly.

¶ Most of the girls (roughly 97 per cent) work between forty and forty-eight hours a week. But when it comes to overtime, only slightly more than 25 per cent are paid for it.

¶ Median pay for office nurses is lowest in towns under 5,000 ($230 a month). It rises, according to the size of the town, to a high of $264 a month in cities of 25,000 to 50,000 population. In bigger cities it's slightly lower.

CAPSULES

A PROGRAM leading to the Master of Science degree in Psychiatric Nursing will be offered by the University of Miami next fall. Made possible by a grant from the National Institute of Health, the new program is the first of its kind in

Florida. A total of eighteen universities in the U. S. now offer the degree.

SALARIES OF Canadian nurses are the lowest among sixteen professions, according to a report in the *Toronto Financial Post*. Annual income of R.N.'s: $1,993, or only $134 more than a hired farm worker. In another article in the same newspaper, it was reported that 4,500 Canadian nurses have emigrated to the United States in the past five years.

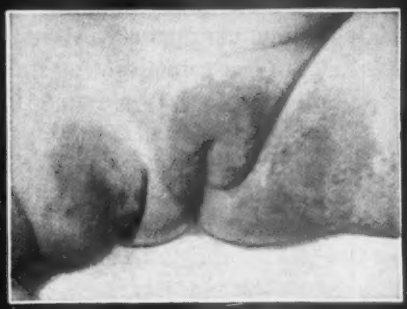
AN EARLIER, more intense interest in nursing by city girls was noted in a recent survey conducted by the University of Wisconsin. Girls from rural areas, on the other hand, consider nursing as only one of several satisfactory careers. Two other survey findings: girls do not usually choose to become R.N.'s until they are seniors in high school; and one-third of freshman college girls had considered medicine as an alternative to nursing.

ABOUT PEOPLE

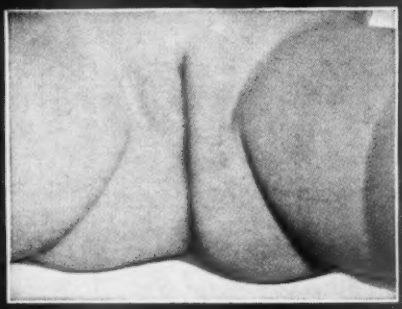
Ellen D. Howland was recently appointed director of nursing at the New England Deaconess Hospital, Boston, Mass. . . . *Sister M. Delrey*, a former Chicago nurse who served for two years in the Navy nurse corps, received the habit of the Religious of the Good Shepherd in ceremonies at the motherhouse in St. Louis recently . . . *Jeanette S. Jackson*, Newark, N.J., has just returned from Liberia where she helped organize a public health nursing program. The U.S. Public Health Service nurse spent almost three years in Africa . . . First woman officer to be sworn into the National Guard is *Norma C. Parson*, Waterville, Maine. Capt. Parson is a member of the nursing staff of the 106th Tactical Hospital at Floyd Bennett Field, N. Y.... R.N.'s associate editor produced a special issue recently. Born to Mr. and Mrs. J. Paul Elder [Frances Lewis Elder] on December 14: a boy, Gregory, eight pounds.

ANC NEWS

Colonel Pauline Kirby, ANC, Chief Nurse at Walter Reed Army Hospital, Washington, D.C., and *Colonel Agnes A. Maley*, ANC, Chief Nurse at Sixth Army, Presidio of San Francisco, are the first in the history of the Army Nurse Corps to achieve the rank of colonel in addition to the chief of the corps . . . *Lt. Col. Isabelle Ann Mason*, ANC, recently returned from Europe and now at Letterman Army Hospital in San Francisco, was presented the honor badge of the German Labor Service in Stuttgart as an expression of friendship from the German civilian staffs with whom she worked . . . *Lt. Col. Mary Gomez*, ANC, is now the Chief Nurse for the U.S. Army Forces, Far East, replacing *Lt. Col. Nina Baker*, ANC, who recently assumed her new duties as Chief Nurse, Medical Section, 1st Army Headquarters, Governors Island, N.Y.



Aug. 25. A typical case of diaper rash, characterized by excoriation and soreness.



Sept. 1. After only one week of local applications with White's Vitamin A & D Ointment each time diaper was changed, the skin surface is normal.

it's becoming routine therapy

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prevention and treatment of diaper rash

and in many other common skin conditions: burns, cuts, sunburn, chafing, prickly heat, chapping, cracked nipples

White's Vitamin A & D Ointment

it's healing...soothing...protective.

Provides A & D vitamins in the same ratio as found in cod liver oil.

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KENILWORTH, N. J.

KEEP A TUBE OF THE NEW
ECONOMICAL 4 OZ. SIZE
HANDY FOR EMERGENCIES
AND ROUTINE SKIN CARE

EDITORIAL

continued from page 35

team are substitutes at the bedside. Isn't this what patients mean when they say:

"I never even see a nurse."

"I didn't know who the nurses were; they were just in and out."

"If only the nurses had more time for the patients!"

"The aides had more time for me than the nurses."

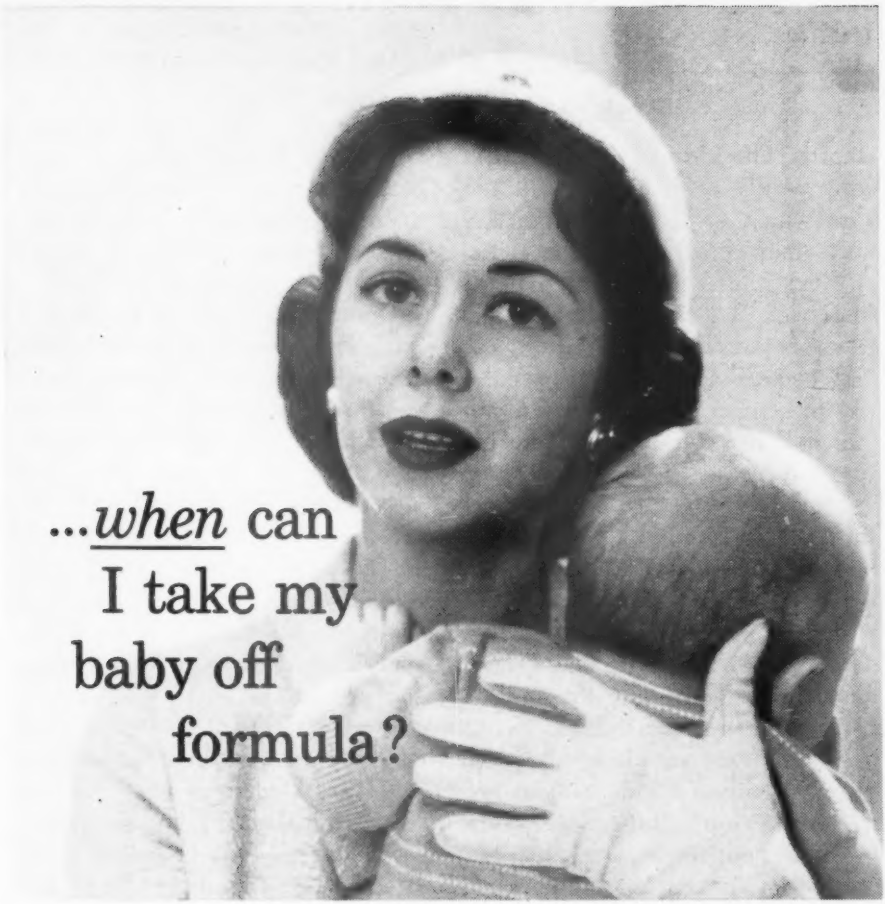
"The nurses were at the desk getting their work done."

All these complaints—fragmentary though they may be—have a central core of grievance.

Similar complaints in the business world are usually righted before they can undermine consumer confidence. Can the nursing profession afford to be less zealous about patient confidence? After all, the patient has something at stake economically: he is paying for *professional* service. If, therefore, he gets less than his money's worth, can we expect him to side with a profession that needs public cooperation in its efforts to further its own economic security?

The acute problem before nursing today is how to hold patients' confidence, retain job satisfaction for nurses, and—at the same time—upgrade nurses to a true professional level. Decisiveness in goals is needed to do all simultaneously with a minimum of trauma.

—ALICE R. CLARKE, EDITOR



Most doctors feel it is wisest to continue the infant's evaporated milk formula for six months, adjusting it from time to time to meet his changing needs. Evaporated milk processing makes it easier to digest than fresh milk. This is an important point, since digestive upsets and diarrheas are more difficult to treat and potentially more serious during infancy.

During baby's important first six months, you can count on the *known digestibility* of his individual evaporated milk formula to give him basic growth protection. It is far wiser to give baby this protection than to try to turn him into an adult too early!

Carnation
"FROM CONTENTED COWS"

Optimum prescription-quality in today's trend to the individualized formula.

continued from page 55

stantly. The aides, however, did a surprisingly good job. Without supervision—*i.e.*, when I was "tied up"—they often nursed the critically sick, the newborn, and patients just back from the O.R. Medications frequently had to wait for the "all clear," and charting usually had to be done after hours—which meant that I rarely got home before 1 A.M.

I partly solved the personnel shortage by inducing family visitors to help out; thus parents helped care for their children, and wives for their husbands—while many a poor father-to-be sweated out a prolonged labor with me as I dashed hither and thither, trying to be in a dozen places at once. These relatives, incidentally, were wonderful; none of them ever complained about the service—at least not within my hearing.

Resourcefulness was an ever-present need—not only in budgeting one's time and in improvising equipment when some needed item was unavailable, but often when a patient's life was at stake and a critical decision had to be made in a hurry.

My own worst experience in this respect came one evening as we were passing the supper trays. The emergency bell rang violently. Rushing down to the door, I found three men dragging in a fourth who, they told me, had just been stung rather painfully by a bee.

One look convinced me that the man was in a bad way. He was cyanotic, his respirations were spasmodic, and I could detect no pulse beat. I told one of his companions to phone for a doctor—even though I felt sure that no doctor could get to the hospital in time.

Frantically trying to recall anything I had ever learned about bee venom, I suddenly remembered these words from a lecture in nursing school: "Antihistamines sometimes help an extreme allergy to insect stings."

Silently blessing the long-forgotten lecturer, I clamped on an oxygen mask, then, to a 5 per cent dextrose solution I added Pyribenzamine—a medication that I gave intravenously.

It wasn't till the doctor arrived (the patient was then out of danger) that I realized with a shock the responsibility I had assumed; yet the doctor took the whole thing as a matter of course. And in due time I came to see how naive I had been to think that I had done anything unusual. Any nurse on that staff would have been expected to assume similar responsibility.

There were many such incidents—enough to fill a book. Enough, too, to fill me with deep respect for all small-town nurses who—unlike those in large hospitals well-staffed with interns and well-supplied with modern equipment—must carry on under trying conditions. It was a great privilege to have shared as I did some of their experiences. «»

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Smartest lines of duty... the tailored tab and the double-tucked streamliner, newest style-wise approaches to your busy hours.

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Nylon Taffeta
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Combed Sanforized Poplin, about $10.
#938 long sleeves only.
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Dacron "Static Free" Taffeta, about $15.
#1564 ¾ sleeves; #1565 short sleeves.
Sizes 10 to 20, 9 to 15.
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Combed Poplin, about $9.
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Sizes 10 to 20, 9 to 15.
#932 ¾ sleeves; #0932 short sleeves.
Sizes 14½ to 24½.

Wherever good uniforms are sold, or write Dept. N2.

BOB EVANS UNIFORM CO., 1508 Harford Avenue, Baltimore 3, Md.

continued from page 61

ing tests failed to show any antibacterial activity. Later, it was learned that the drug stopped the growth of microorganisms only when broken down in the body to an active metabolite. More recently, it has been found that the new antibiotic, cycloserine, relatively ineffective in the test tube, becomes a potent antituberculosis agent when put through the body's metabolic pathways.

To minimize mistakes due to such variability in the way different species react to drugs, medical scientists usually study the rates of absorption, distribution, and elimination of new drugs in several species of animals and, finally, in humans. These studies often aid in determining the dosage form, and method of administration best suited for human use. Such drugs, as insulin, ACTH, and streptomycin must be given by injection to produce systemic effects. Others are specially prepared to overcome unfavorable rates of absorption and excretion. Penicillin, for example, tends to leave the body too rapidly to exert its antibacterial action; consequently, methods have been devised to increase its resistance to break down in the body as well as to reduce its solubility and its rate of renal excretion.

The final test of a drug's value is, of course, the extent of its effectiveness in clinical trials. These must be conducted by highly qualified medical men so as to minimize the risk to patients and the chances of erroneous evaluation. Thus, the doctor doing the tests—usually a specialist in the disease being treated—must be thoroughly aware of all the pharmacodynamic details revealed by the experiments with animals.

The first doses given to patients are only small fractions of the amounts found to be tolerated by animals. Usually these are too small to be effective and must be raised gradually until dosage is both effective and safe. After such preliminary trials have shown the drug to be beneficial to the most

severely ill patients in doses that cause few ill effects, more extensive tests utilizing hundreds, or even thousands, of carefully selected and classified patients must be carried out.

Because of the complex and variable ways in which people react to drugs, the investigator must use utmost caution in planning his experiments and analyzing the results. All too often, failure to control important variables invalidates the results of clinical trials. One of the most important sources of error appears to be the fact that emotional and psychological factors influence both the patient's response to medication and the doctor's evaluation of his response. Some patients feel better no matter what they are given; they are influenced by their intense desire to get well and their gratification with the special attention given them by the attending physicians and nurses.

To ensure unbiased reactions, some investigators now use a "double blind" type of study in which neither the doctor nor his patient knows whether the active drug or an innocuous placebo (such as lactose tablets or saline solution) is being administered. The records are kept by a nurse or some other member of the team who may never even see the patient. Such "blind" studies with coded drugs have revealed that a surprisingly high number of people—as many as 50 per cent—are "placebo reactors," reporting relief of headaches, colds, and anginal pain when treated with nothing more than simple sugar or saline.

While great advances have been made in putting drug therapy on a rational basis, most of the medicines in use today have been developed through a system which, though more scientific than the primitive observations of antiquity, is still essentially empirical—based on trial and error.

However, a real understanding of the ways in which drugs of certain chemical structure act to alter cellular metabolism will be achieved only after biochemists and physiologists have laid bare the mysteries of cellular structure and function. «»

SOCIAL SECURITY

continued from page 63

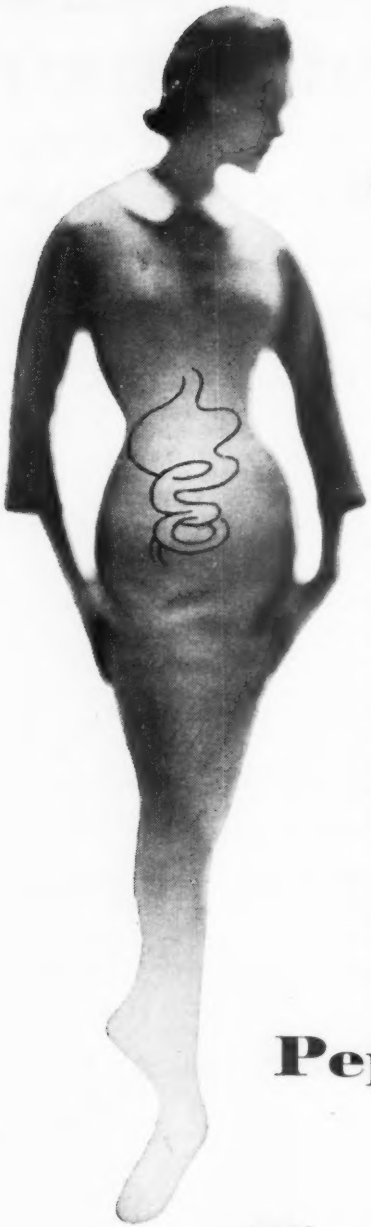
1909 or later, and a male R.N. born in 1906 or later, both require at least forty quarters; those born before 1909 and 1906 respectively require fewer than forty quarters; but in no case can an individual qualify for benefits without at least six quarters of coverage.

Q. How much will I now pay for my Social Security, and how?

Beginning January 1, 1957, each member of the armed forces is taxed, via payroll deduction, 2¼ per cent of his or her basic pay up to $4,200 a year. The government, as employer, pays an amount equal to that of each individual. These payroll taxes are identical with those paid by civilian employers and employes.

Q. Where can I obtain further information about this new phase of the Social Security program?

Army Circular 608-18, issued recently, gives a comprehensive outline of the benefits for which service personnel may qualify. The Social Security Administration makes available Fact Sheet OASI-1956-3 which explains the rights of service personnel and veterans under the amended law. Individuals seeking specific information pertaining to their own circumstances are advised to consult the nearest Social Security office. «»



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ADMINISTRATORS: (a) Male Nurse Adm. 40 bed fairly new hosp Mich. resort area (b) 60 bed convalescent hosp, direct all activities. $5000. up, mtce. NY. RN2-1 Burneice Larson, 900 N Michigan Ave., Chicago, Ill.

ANESTHETIST: Experienced or a recent graduate. Good recommendations, 5 day wk, 8 hr day, starting salary $485 per mo. For full information write Administrator. Leila Y. Post Montgomery Hospital, Battle Creek, Mich.

ANESTHETIST NURSE: Modern nearly new 118 bed hospital, to $500 40 hr wk, other benefits. Write Administrator, Coffeyville Memorial Hospital, Coffeyville, Kans.

ANESTHETISTS: (a) Small research clinic, no call duty, San Francisco Bay area, start $5200. (b) Take complete charge surgery, 45 bed hosp, best equipment, Wisc. ski, fishing country. $5000 plus fee percentage. (c) Chief, head dept. of 4, 200 bed gen'l hosp, excellent opportunity, financially. Western NY. (d) 2, no OB, 8 modern surgical suites, 250 beds, state cap, univ center, MW. to $6600. (e) Head dept, 40 bed hosp, centrally located winter-summer resort, ideal situation, top salary. (f) Combination Anes-Director, 20 bed new hosp. Tex. Above average compensation. RN2-2 Burneice Larson, Medical Bureau, 900 N Michigan Ave., Chicago, Ill.

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ATTRACTIVE OPPORTUNITY NURSES: In progressive 166 bed new hospital, fully approved, located in western mining city. 5 day wk. 40 hrs, 6 pd holidays, 14 days accumulative sick leave, 14 days vacation, meal on duty, starting salary $270, $20 differential for pm, $15 for night duty, $25 bonus call for O.R. Increases every 6 mos, $5. Write Director, Nursing Service, Butte Community Memorial Hospital, Butte, Mont.

BEDSIDE NURSES: Acute medical and surgical services, $3500-$4580. Advance rapidly Apply Supt. of Nurses, Goldwater Mem. Hosp Welfare Is., New York 17, MU 8-3500.

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CLINICAL INSTRUCTOR: For Practical Nurses School, salary based on preparation and experience, liberal personnel policies, 40 hr wk. Apply to Mrs. Pauline R. Wescott, Director of Nurses, Northampton-Accomack Memorial Hospital, Nassawadox, Va.

CLINICAL INSTRUCTOR IN MEDICAL & SURGICAL NURSING: Degree preferred. Position available at university affiliated N.L.N. fully accredited school of nursing. Liberal personnel policies include tuition aid for advanced study. Write to: Department R.N., Director of Nursing Service, Mount Sinai Hospital, 1800 E. 105th St., Cleveland 6, Ohio

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DIRECTOR OF NURSES: 210 bed general hospital. Desire person with administrative training and/or experience. Director in complete charge of nursing personnel. 40 hr wk. Located in heart of beautiful Wyoming. Prefer B.A. or B.S. Degree. Excellent starting salary with opportunity for salary advancement. See article in June "Modern Hospital Magazine" for information about hospital. For further details write Administrator, Memorial Hospital, Casper, Wyo.

DIRECTOR OF NURSES, EXPERIENCED: No degree necessary. No school, 140 bed approved hospital. Social Security and hospital retirement plan. Private apartment available. Attractive salary, population over 65,000. Also wanted, Night Supervisor, 15 bed Pediatric Head Nurse. Apply Administrator, Fort Hamilton Hospital, Hamilton, Ohio.

DIRECTOR OF NURSING: Excellent opportunity to demonstrate your ability and use initiative directing activities of large nursing service in modern tuberculosis hospital. Preference given applicants with degree and responsible supervisory experience. Liberal holiday, vacation and illness allowances. Salary $5100 to $6000, depending upon qualifications. Please send detailed resume of training and experience to Personnel Director Board for Texas State Hospitals and Special Schools, Box S. Capitol Station, Austin, Tex.

DIRECTOR OF NURSING EDUCATION: Ambitious nurse with degree to be responsible for two-year college training program in large tuberculosis hospital. This may be the opportunity you seek and merit. Liberal holiday, vacation and illness allowances. New air-conditioned building. Salary $4500. Please send detailed resume of training and experience to Personnel Director, Board for Texas State Hospitals and Special Schools, Box S, Capitol Station, Austin, Tex.

DIRECTORS OF NURSING: (a) Nurse Consultant, National health welfare organization, Connecticut. Top salary for right person. (b) Head, newly created Dept. of Nursing of University estab 1850, challenging opportunity, complete organization, curricu'um, counseling, faculty status, academic year. (c) Complete responsibility for nursing service, re-

nowned university hosp, 1000 beds, must be adm of highest caliber, faculty appt, salary commensurate ability. (d) Head, Practical Nurse Program, Public School System, N.Y. (e) Dir. Service, Education, 350 bed gen'l hosp, 200 students, Deep South. $6000 up, mtce. (f) Asst. Dir. ready to assume responsibility as Dir. of school, service, 150 bed hosp with expansion prog to 250, Texas oil center, to $7200. RN2-3 Burneice Larson, Medical Bureau, 900 N. Michigan Ave., Chicago, Ill.

EDUCATIONAL DIRECTOR: Hospital School of Nursing in new 300 bed hospital, 30 mins. from NYC. Write stating education and experience. Box C-140 c/o R.N. Magazine, Oradell, N.J.

FACULTY POSTS: (a) Instructor Office Nurse technique, small coed college, MW. $550 mo. (b) Asst. Prof. Ped., renowned univ dept of nursing, near NYC, $500 mo, also Med. Surg. (c) Dir. of educ. noted progressive 400 bed hosp outside US. English speaking faculty, 180 students, to $6600. (d) Psych. Inst., newly org. coll school, lake campus, metro area, leading MW city, to $560 mo. RN2-4 Burneice Larson, Medical Bureau, 900 N Michigan Ave., Chicago, Ill.

GENERAL DUTY: 40 hr wk, 84 bed hospital, finest equipment, very liberal personnel policies and pleasant working environment. Must be willing to rotate shifts. Salary range $277 to $360 monthly. Atomic Energy Project but not Civil Service. Write Director of Nursing Service, Los Alamos Medical Center, Los Alamos, N.M.

GENERAL DUTY & OPERATING ROOM NURSES: Wanted immediately for 150 bed hosp. 40 hr wk with liberal personnel policies. Nurses Home available at reasonable rates. All-graduate nursing staff. Apply Dir. of Nurses, Morrell Memorial Hospital, Lakeland, Fla.

GENERAL DUTY NURSES. For continuing expansion. Applications now being accepted for January 1957 opening of new addition of modern Chicago hospital, ideally located on beautiful north side lakefront near parks and beaches. Staff nurses start at approx. $355 per mo fpr pm's and night $325 per mo for days, 40 hr wk. Positions open on rotating or straight pm's or nights. Equipped with nurse-to-patient communication system, piped oxygen at every bed, spacious nursing stations, excellent working environment. Many liberal employee benefits including free Blue Cross, one half tuition for college level courses related to work. Co-operative administrative group which maintains high standard of patient care. Presently 180 bed hospital expanding to 250 beds, which insures exceptional opportunity for advancement. Write Personnel Director, Louis A. Weiss Memorial Hospital, 4646 Marine Drive, Chicago 40, Ill.

GENERAL DUTY NURSES: For 40 bed general hosp est. 1950. Well equipped. Salary $1.50 per hr, 44 hr wk, salary increases at 6 mos to 1.62½, 12 mos to 1.75 per hr. Annual pd vacation of 2 wks, meal while on duty. Attractive living quarters available, reasonable. Apply Director of Personnel, Safford Inn Hospital, Inc., 625 Central Ave., Safford, Ariz.

GENERAL DUTY NURSES: Would you like to enjoy the vacation land of America? Winter skiing, summer horseback riding, see Yellowstone National Park. Read all about this area in January 1956 issue of National Geographic. Excellent personnel policies, 5 day wk, 8 pd holidays, salary $260, differential $10 for p.m. and nights. Permanent and summer relief positions open. Please apply Superintendent of Nurses, St. John's Hospital, Jackson, Wyo.

GENERAL DUTY NURSES: For 135 bed general hospital. Organized medical staff, high quality services, pleasant surroundings, comfortable living conditions in nurses home, excellent personnel policies. Apply Director of Nursing, John D. Archbold Memorial Hospital, Thomasville, Ga.

GENERAL DUTY NURSES: 210 bed teaching hospital 35 mi from NY. 40 hr wk, $30 differential for eve duty, $20 night. Regular increments, liberal sick lv, vacation, 8 holidays, Social Security, uniform laundry, living facilities provided. Director of Nurses, White Plains Hospital, White Plains, N.Y.

GENERAL DUTY NURSES: 118 bed general hospital located in a beautiful residential section along the North Shore of Chicago. Starting salary $300 a month, bonus of $30 for evenings and $20 for nights. 40 hr. wk. Modern ranch style nurses' homes with attractively furnished private bedrooms. Contact Director of Nursing Service, Highland Park Hospital Foundation, Highland Park, Ill.

GENERAL DUTY NURSES: Interesting work and environment, salary and quarters excellent. Write MMM Hospital, Nome, Alaska

GENERAL DUTY NURSES: 50 bed approved hospital located in mountainous portion of Colo. College town. Salary $275, 40 hr wk, sick leave, vacation bonus. Contact Superintendent, Community Hospital, Alamosa, Colo.

GENERAL DUTY NURSES: 120 bed hospital, southern Wyoming community of 12,000. Liberal personnel policies, 40 hr wk. Starting salary $280 with a charge of $23 for full maintenance. Additional $10 per mo. for evening and night duty with regular increases. Surgical Nurses starting salary $290 plus $5 per call after 5 p.m. Nurses' Home recently redecorated and refurnished. Write Director of Nurses, Memorial Hospital, Rock Springs, Wyo.

GENERAL DUTY NURSES—AT MEDICAL CENTER: Start $275 for 40 hr wk, $5 increases at 3, 9 and 15 mos, and $10 increase after 24 mos., overtime premium pay, 2 wks paid vacation, 6 pd holidays, sick leave, free medical services, Social Security. We pay hospital insurance, life insurance, retirement annuity. Apply Personnel Director, Rochester Methodist Hospital, Rochester, Minn.

GENERAL DUTY STAFF NURSE: New and modernized 300 bed general hospital offers top salaries and opportunities to advance. Evenings $76.80-$89.60 per wk, nights $73.60-$86.10, days $64.00-$75.60. Openings in Medical, Surgical, Obstetrics, Pediatrics, Operating Rooms and Emergency Room. 40 hr wk, merit increases, liberal policies. On Long Island Sound, 45 mins to N.Y.C. Modern nurses residence and school. Apply Director of Nursing, Stamford Hospital, Stamford, Conn.

GENERAL DUTY STAFF NURSES: For evening and night duty, 40 hr wk, vacation and sick leave, salary daily rate, minimum earnings $312 per mo. Apply Director of Nurses, Englewood Hospital, 6001 S. Green St., Chicago 12, Ill.

GENERAL DUTY, SURGICAL & PEDIATRICS NURSES: For 275 bed general hospital in residential suburb of Chicago. 40 hr. wk. Cash salary and live in: $265 day duty, $275 pm duty, $280 night duty—plus private room

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1. Stieglitz, E. J.: in Modern Nutrition in Health and Disease, ed. by Wohl, M. G. and Goodhart, R. S., Lea and Febiger, Philadelphia, 1955, p. 945.

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in new nurses' residence, 3 meals per day and free laundry of uniforms. Cash salary and live out: $310 day duty, $320 pm duty, $325 night duty—plus one meal and free laundry of uniforms. Low rental apartments available for married nurses. Planned service increases at regular intervals. Many other benefits. Write Personnel Director, MacNeal Memorial Hospital, Berwyn, Ill.

GENERAL STAFF NURSES: For 200 bed general hospital. Openings in Ped, O.B. & Med.-Surg. Minimum starting salary $255. 40 hr work wk, special consideration given for experience and qualifications. Merit increases at 6 mo, 12 mo and annually thereafter. Evening and night duty differential $10. Good personnel policies. Rooms available $20 per mo. Write Dir. of Nursing Service, Memorial Hospital, Casper, Wyo.

GENERAL STAFF NURSES: Because we are friendly people it is fun to work in the preferred department of a 200 bed JCAH general hospital enthralled in the extensive building program creating opportunity for advancement. Liberal personnel policies include 40 hr wk, retirement plan, Social Security, pd hospitalization insurance premiums, cumulative 30 days sick leave, 2 wks vacation, 6 holidays, excellent meals at cost, cozy rooms at $20 per mo, in-staff educational program. Approximate initial salary eves $349, nights $343, days $325. Annual increase yearly approximates $215. High standard patient care maintained by nurses permitted to use professional preparations. Ideally located near Detroit with convenient transportation to make off duty hrs. interesting. For details write Director of Nursing, Wyandotte General Hospital, Wyandotte, Mich.

GENERAL STAFF NURSES: 270 bed general hospital and 72 bed maternity hospital. Starting salary $305 a month. $5 month tenure increase for each 6 mos to maximum of $335. $25 additional for afternoon and night. $25 additional for surgery. Liberal paid annual vacation. 7 paid holidays, 8 hr day and 40 hr wk, Social Security and employer-paid health and life insurance program. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GENERAL STAFF NURSES: For 60 bed hospital very well equipped and modern, located in northern Florida. Good personnel policies, increase in salary every 6 mos, holidays with pay, sick leave with pay and pd vacation. Apply Directress of Nurses, Catherine M. Hurst, R.N., Suwannee County Hospital, Live Oak, Fla.

GRADUATE NURSES: For 55 bed general hospital located on coast of South Carolina within few miles of beautiful drives. Good beaches and famous gardens. Deilghtful climate in city of 15,000 population. Expansion program now in progress insures opportunity for advancement. New modern nurses residence near the hospital. Positions open on rotating and straight shifts. Excellent personnel policies. Good salary with full maintenance, 40 hr wk, automatic salary increases, Social Security and Blue Cross pd by hospital. Contact Superintendent of Nurses, Georgetown County Memorial Hospital, Georgetown, S.C.

GRADUATE NURSES: For medical and surgical services, modern 263 bed mid-Manhattan hospital. 5 day, 40 hr. wk. Starting salary, scrub nurses, O.R. $301, floor duty $291, Eves. $330, nights, $320. uniform laundry. Four annual increases, 4 wks. vacation, 11 holidays, sick leave 12 days per year cumulative, social security health service, free hospitalization. Opportunities for special assignments, research nursing bonuses and supplementary study. Housing agent available. Apply Supt. of Nurses, James Ewing Hospital, 1250 First Ave., New York 21, N.Y.

GRADUATE NURSES: Positions for those who either have or are willing to obtain Colorado registry. Floor duty, rotating shifts, uniform laundry and meals furnished, 2 weeks paid vacation and 7 days sick leave per year. 35 bed hospital in a growing community. Southwest Memorial Hospital, Cortez, Colo.

GRADUATE NURSES: For general duty, 75 bed general hospital, new, air-conditioned with modern equipment. Beginning salary $250 a mo with differential for evening and night duty and operating room nursing. Good personnel policies. 5 day, 40 hr wk, vacation, pd sick leave, holiday time. Located in beautiful central Florida. Apply Director of Nurses, Seminole Memorial Hospital, Sanford, Fla.

GRADUATE REGISTERED NURSES: For Medical, Surgical, Obstetrical and Pediatric services 150 bed general hospital, 40 hr wk, accumulative sick leave to 30 days, annual vacation of 3 wks, 6 holidays, Social Security and Blue-Cross benefits. Salary, staff nurses $255-$270, 7-3 duty, $15 differential for 3-11 and 11-7 duty. Apply Director of Nursing, Schoitz Memorial Hospital, Waterloo, Iowa.

GRADUATE STAFF NURSES: For Medical, Surgical and Obstetrical Services. Also vacancies on operating room staff. Salary $265 per mo for 8 hr day 40 hr wk. Annual vacation and sick leave. Retirement benefits if desired. Apply Administrator, Robinson Memorial Hospital, Ravenna, Ohio.

HIGH CALIBER REGISTERED NURSES: We need good nurses interested both in latest scientific therapy and old-fashioned warm care of patients with cancer and allied diseases. Teaching and Research Center offers valuable experience. Adequate staff of top nurses maintained University-affiliated inservice education, access all NYC educational programs. Good basic preparation required, learn specialty here where patients receive active surgical-medical-radiation therapy. NOT a chronic disease hospital. Teachers College Learn-Earn Plan available for study-experience program on full salary. Staff Nurses day $291-331 mo, eve, $346-386 mo, nite $335-375, 4 wks vacation, 1½ pay for overtime, uniforms laundered, Blue Cross pd by Center. Housing agent helps you locate. Thelma Laird, R.N., Director of Nursing, Memorial Center, 444 E 68th St., NYC 21, N.Y.

INDUSTRIAL NURSES: Registered male and female nurses for large industrial hospital. 40 hour week, liberal sick leave policy, company paid life insurance, hospitalization and surgical benefits. 7 paid holidays. Helen Wortman, F. C. Page, Sales and Office Personnel, The Goodyear Tire & Rubber Co., 1144 E. Market St., Akron 16, Ohio.

INDUSTRIAL, OFFICE: (a) Top notch office Asst, leading plastic surgeon, NYC, ability in research, medical editing. (b) Courier Nurses, stewardnesses, air, rail. East, South, West, Overseas. To $365, expenses. RN2-5 Burneice Larson, 900 N. Michigan Ave., Chicago, Ill.

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College Learn-Earn Plan now open to O.R. nurses combines study with experience at full salary. Good basic preparation needed, learn specialty here. $291-346 mo plus ½ pay for on-call hours. 4 wks vacation, other benefits. See our ad "High Caliber Registered Nurses" above. Thelma Laird, R.N., Director of Nursing, Memorial Center, 444 E. 68th St., New York 21, N.Y.

INSTRUCTOR IN NURSING ARTS: Immediate opening. Salary range $410-470. Not over age 50, 250 bed hospital, thoracic diseases and chronic illness rehabilitation. American Citizen, Calif. registered. Send personal record, references and recent photo to Medical Director, Tulare-Kings Counties Hospital, Springville, Calif.

INSTRUCTORS-NURSING ARTS & SCIENCE: For school of nursing in 110 bed general hospital. Degree in Nursing or Nursing Education preferred but work toward degree required. Starting salary $300 to $350 with maintenance depending on training and experience. Apply Administrator, Camden Hospital, Camden, S.C.

MEDICAL-SURGICAL SUPERVISOR, ADMINISTRATIVE: 500 bed voluntary hosp. 10 mi from NYC with direct transportation to Times Square in 35 mins. Universities and colleges available both in NY and NJ for further education. B.S. Degree and/or satisfactory experience in supervision preferred but will consider person with satisfactory experience working towards degree. Salary dependent on education and experience. 40 hr wk, 2 holidays with full pay, 4 wks vacation yearly, liberal sick leave. Write to Director of Nursing, Newark Beth Israel Hospital, 201 Lyons Ave., Newark 12, N.J.

NEW YORK UNIVERSITY MEDICAL CENTER: Offers graduate nurses full time work in all services at its University Hospital (formerly N.Y. Post Graduate Hospital) at a starting salary of $290 mo. Planned increments starting after 6 mos of service, $40 and $20 premiums for eve and night duty, 4 wks vacation, pd holidays, liberal personnel benefits including a Free Tuition Plan at NYU which gives excellent opportunities to earn your degree or take special advanced courses while you are earning your living. Apply Personnel Dept., 550 First Ave., New York 16, N.Y.

NURSE ANESTHETIST: Excellent working conditions, $400 per mo with annual increases of $25 per mo to maximum of $500. 3 wks vacation after 1 yr, minimum 2 wks sick leave. Usual employee benefits. Lexington is located in the "Heart of the Bluegrass" famous for horse racing and tobacco industries, home of University of Kentucky and Transylvania College. Apply Assistant Administrator, Good Samaritan Hospital, South Limestone St., Lexington, Ky.

NURSE ANESTHETIST: For modern 114 bed general hospital with air-conditioned surgery located 50 mi south of Washington, D.C. Staff of one physician and 2 nurse anesthetists. On call every 3rd night and weekend and not scheduled following day. Minimum salary $450 per mo. Reply Administrator, Mary Washington Hospital, Fredericksburg, Va.

NURSE ANESTHETIST: 100 bed hosp. New hosp. being constructed. Salary open. Apply Nathan I. Kantor, M.D., Chief Anesthesia, Warren Hospital, Phillipsburg, N.J.

NURSE ANESTHETIST: To complete staff of 4 in 500 bed 2 yr old hosp. Salary according to experience with annual increases. New equipment and all types of surgery. Take call at home. No scheduled cases on Saturdays. Additional information from Dr. Alfred M. Keirle, Chief Surgical Service, Veterans Administration Hospital, 3200 Vine St., Cincinnati 20, Ohio

NURSE ANESTHETIST: For approved general hospital. Must be able to administer latest types of anesthetic agents. Salary $375 to $400 per mo plus full maintenance. Annual vacation and sick leave. Retirement benefits if desired. Apply Administrator, Robinson Memorial Hospital, Ravenna, Ohio.

NURSE ANESTHETISTS: Centrally located general hospital of 400 beds. Openings in OB and OR. Excellent salary, automatic increases, liberal personnel policies. Medical Anesthesiologist in charge. Write or call Personnel Director, Providence Hospital, 2500 West Grand Blvd., Detroit 8, Mich.

NURSE, R.N.: for est. Vermont girls camp. $425, July & Aug. Write Room 1605, 11 Broadway, New York 4, N.Y.

NURSES: Registered Operating Room. 150 bed privately-owned hospital. 40 hr wk, 2 wks vacation, 5 holidays, pension plan, group life insurance, complete maintenance. Salary open, additional pay for call. Contact Personnel, Southwestern General Hospital, El Paso, Tex.

NURSES: Graduate, registered, staff, inservice education, liberal personnel policies, rotating shifts. Located near Gulf. Social Security and retirement plan available. Starting

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Dosage: 2 Gelusil tablets or 2 teaspoonfuls of Gelusil liquid two hours after eating or when symptoms are pronounced. Each tablet or teaspoonful provides: 7½ gr. magnesium trisilicate and 4 gr. aluminum hydroxide gel. Gelusil-Lac: at bedtime, one heaping tablespoonful stirred rapidly into one-half glass (4 fl. oz.) of cool water. (Provides equivalent of 4 Gelusil tablets.)

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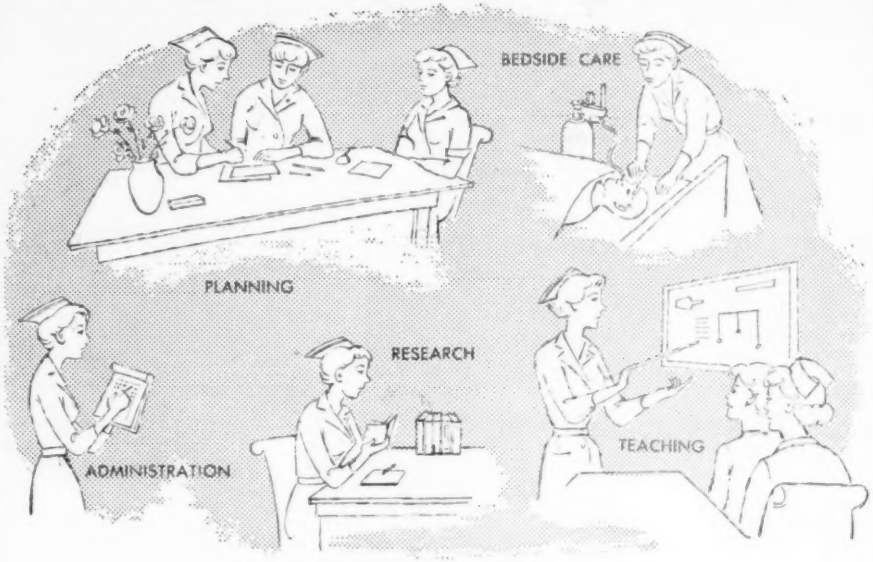

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salary $300. Apply Nursing Supervisor, Polio Center, 1801 Buffalo Drive, Houston 3, Tex. CA 4-7875.

NURSES: Modern 200 bed, fully accredited hosp. in beautiful Cumberland Valley college town, has openings in General Duty (Medical and Surgery), Operating Room, Pediatrics, Maternity and Nursery. Friendly, informal atmosphere. 40 hr wk, 7 pd. holidays. Free hospitalization, Social Security, 2 wks vacation after 1 yr, other benefits. Apply Dorothy D. Bollinger, R.N., Director of Nursing, Chambersburg Hospital, Chambersburg, Pa.

NURSES: We, an expanding 224 bed nonsectarian general hospital, JCAH approved with temporary NLN Accredited School of Nursing, located near Stewart Field Air Base and West Point, one hr from NYC, and half hr. from resort areas have the following to offer you: Openings at all levels with differentials for eve and night duty, bonus for OR call, 40 hr wk, Social Security, cumulative sick leave, half Blue Cross premiums pd by hospital, 7 pd holidays, low cost cafeteria, regular merited increments, educational subsidies, social and advancement opportunities, excellent personnel policies, in-service education, health program, friendly cooperative working relations and conditions, air-conditioned operating room and recovery room, democratic philosophy and constant improvements in physical plant, equipment, personnel policies and nursing care. We are interested in you. Contact Director of Nursing, St. Luke's Hospital, Newburgh, N.Y.

NURSES: General hospital, 236 beds, new building, modern equipment. 30 miles from New York City. Liberal personnel policies. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N.J.

NURSES: General Duty, for 30 bed hospital 35 miles from New York. Excellent salary. Apply Administrator Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

NURSING SERVICE DIRECTOR: Ass't. Attractive position for qualified applicant. Northern New Jersey. Write stating education and experience. Box B-140 c/o R.N. Magazine, Oradell, N.J.

O.B. SUPERVISOR: We have immediate opening (Degree or Post-Graduate). Will be used as Floor Supervisor and Clinical Instructor. Salary open. 210 bed hosp, good personnel policies, city of over 60,000. Write or call collect Director of Personnel, Sioux Valley Hospital, Sioux Falls, S. Dak.

OBSTETRICAL NURSES: For new, ultra modern Obstetrical Unit opening March '57. Applications now being accepted for Post Partum, Nursery, Labor and Delivery Rooms. Head Nurses $350 per mo. Staff Nurses $355 pm and nights. $325 rotating for 40 hr wk. Equipped with nurse-to-patient communication system, piped oxygen at every bed, spacious nursing stations, excellent working environment. Many liberal employee benefits, including free Blue Cross, one-half tuition for college level courses related to work. Cooperative administrative group which maintains high standard of patient care. Presently 180 bed hospital, expanding to 250 beds, which insures exceptional opportunity for advancement. Write Personnel Director, Louis A. Weiss Memorial Hospital, 4646 Marine Drive, Chicago 40, Ill.

OPERATING ROOM NURSES: For 200 bed hospital. Openings for Ass't Supervisor and Staff. Minimum starting salary $255. 40 hr

work wk, Special considerations given for experience and qualifications. $20 per mo for call. Average call 2 nights per wk. Good personnel policies, rooms available $20 per mo. Write Director of Nursing Service, Memorial Hospital, Casper, Wyo.

OPERATING ROOM NURSES: For 165 bed general hospital. 30 hr wk, vacation and sick leave, salary daily rate, minimum earnings $325 per mo. Apply Director of Nurses, Englewood Hospital, 6001 S. Green St., Chicago, Ill.

OPERATING ROOM NURSES—AT MEDICAL CENTER: Start $285 for 40 hr wk $5 increase at 3, 9, and 15 mos., $10 increase after 24 mos. Overtime premium pay, paid vacation, 6 paid holidays, sick leave, free medical services. Social Security. We pay hospitalization insurance, life insurance, retirement annuity. Apply Personnel Director, Rochester Methodist Hospital, Rochester, Minn.

OPERATING ROOM SUPERVISOR: Advanced preparation preferred, capable of assuming teaching responsibility. 100 bed hospital located on Eastern Shore of Virginia. 44 hr wk, salary open. Apply to Mrs. Pauline R. Wescott, Director of Nurses, Northampton-Accomack Memorial Hospital, Nassawadox, Va.

OPERATING ROOM SUPERVISOR: Complete new surgical suite, 200 bed hospital. Salary open. Suburban Hospital, Bethesda, Md.

OPERATING ROOM SUPERVISOR: Experience desirable but not necessary. Sick leave and annual vacation. Retirement benefits available. Salary open. Apply Administrator, Robinson Memorial Hospital, Ravenna, Ohio.

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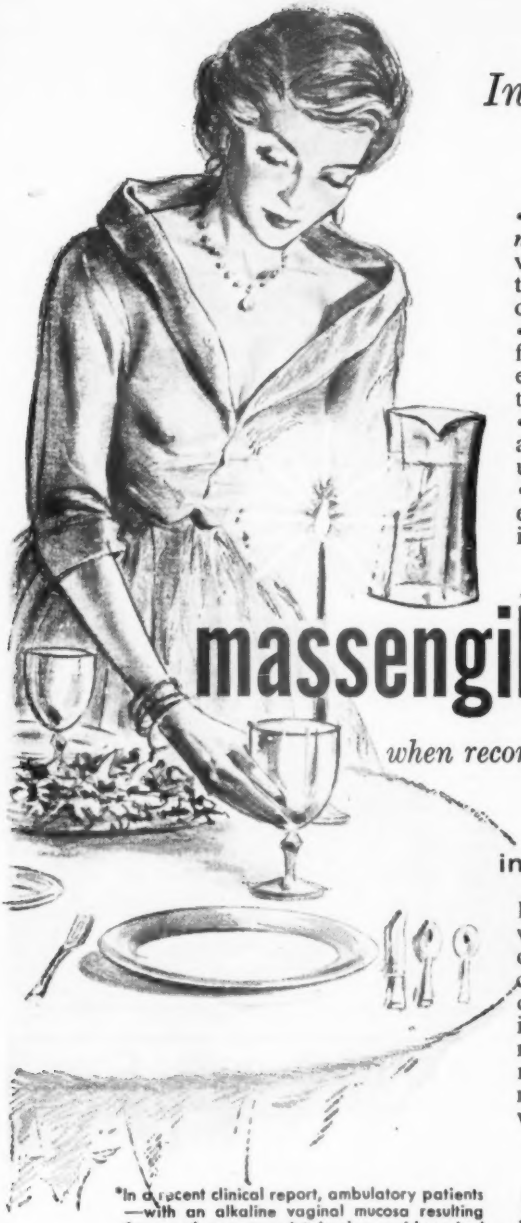

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REGISTERED NURSES: 2 for 35 bed private hospital. 40 hr wk, $300 per mo plus meal allowance to start, $10 increase after 3 mos. Write Mr. Koch, Casita Hospital, 82-485 Miles Ave., Indio, Calif.

REGISTERED NURSES: 65 bed general hospital located 40 mi from Dallas, Tex. Starting salary $260 per mo. plus laundry of uniforms and one meal per day. Living quarters available. Apply Director of Nurses, City-County Hospital, McKinney, Tex.

REGISTERED NURSES: Are you looking for something new? Staff and Ass't Head Nurse positions open in beautiful new University of Oregon Medical School Hospital located on hill overlooking Portland, Ore. Medical, Surgical, Pediatric and Psychiatric units. Excellent opportunities for learning, both in clinical areas and on campus. Staff members may take courses at reduced tuition rate ($3 per quarter hr) leading to baccalaureate or Masters Degrees at the Nursing School on campus. Liberal personnel policies. The Northwest is a wonderful place to live and work. Write to Director of Nursing Service for full information, U of O Medical School Hospital, 3181 SW Sam Jackson Park Road, Portland 1, Ore.

REGISTERED NURSES: General staff duty. Beginning salary $285 per month and $10 shift differential, 40 hr. wk., 7 pd. holidays, yearly vacation, health insurance program. Uniform laundry provided. Mark Twain Hospital District, San Andreas, Calif.

REGISTERED NURSES: Gen duty, 25 bed hosp, starting salary $275 per mo, room and board, 40 hr wk, rotating shifts, 8 holidays, sick leave, vacation. Apply to Director of Nurses, Mineral County Hospital, Hawthorne, Nev.

REGISTERED NURSES: For Veterans Administration Hospital, Fort Howard, Maryland, located 15 mi from Baltimore. 437 bed GM&S Hospital. Personnel policies include 40 hr wk, 30 days annual leave, 15 days sick leave and 8 holidays. Salaries, Junior Grade $4025, Associate Grade $4730 with yearly increases. Non-housekeeping quarters available. Uniform allowances and laundry provided. Openings for both men and women interested. Contact Chief, Nursing Service, VAH, Fort Howard, Md.

REGISTERED PROFESSIONAL NURSES: For supervisory, educational and general staff positions. Liberal personnel policies. 40 hr. week. Differential salary for evening, nights and operating room. Social Security. Christ Hospital, 176 Palisade Ave., Jersey City, N.J.

REGISTERED STAFF NURSES: Never a dull moment for the graduate nurses who decide they would like to join us at the University of Texas Medical Branch Hospitals. We work a 40 hr wk in our air-conditioned hospitals leaving 128 hrs to enjoy the beach and nearby resorts. Galveston boasts an average temperature in the low 70's which means that swimming, fishing, horseback riding and sailing can be enjoyed year 'round. We have positions available in the clinical area of your choice. Staff nurses monthly salaries begin at $264 for rotation and $277 for extended eves or nights. Uniforms laundered free. Liberal personnel policies and opportunities for advanced study leading to both B.S. and M.S. Degrees. Write for further information to the: Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Tex.

STAFF NURSES: For operating room, obstetrics, medical and surgical nursing. Apply Director of Nurses, St. Mary's Hospital, West Palm Beach, Fla.

STAFF NURSES: Needed for Fairmount Hospital of Alameda County, Calif. $306-$356 per mo. Several vacancies in post-polio respirator center-previous experience in this field not required but taught on the job. 2 Head Nurse II, $356-$414 per mo. 2 Supervising Nurses, $394-$459 per mo., 1 for med. wards,

1 psychiatric custodial. Personnel policies applying to all: 40 hr 5 day wk, differential afternoon or night work. Uniforms laundered without charge. Vacation—11 working days a yr after 6 mos and 15 working days after 5 yrs. Sick leave, as needed—after 6 mos up to 11 working days, after 1 yr, up to 22 working days per yr, after 5 yrs up to 44 working days. Apply Director of Nurses, Fairmount Hospital of Alameda County, 15400 Foothill Blvd., San Leandro, Calif.

STAFF NURSES: For all departments. Modern 190 bed general non-sectarian hospital located in beautiful Southwestern Michigan. 90 mi from Chicago. 40 hr wk, 8 hr tours. Excellent salary, good personnel policies. Nurses working toward a degree may be interested in our Community College. Apply Director of Nursing Service, Mercy Hospital, Benton Harbor, Mich.

STAFF NURSES: For 82 bed fully approved general hospital, 44 hr wk. Paid vacation and sick leave. Vacancies on all shifts. Apply Administrator, Fairfield Memorial Hospital, Fairfield, Ill.

STAFF NURSES: 300 bed general hospital located in the Hollywood District of sunny California. Beginning salaries $300-$315 per mo, maximum $330-$355, 5 day wk, 6 holidays, pd vacation and sick leave. For further information write Director Nursing Service, Hollywood Presbyterian Hospital, Los Angeles 27, Calif.

STAFF NURSES: For 225 bed Southern California hospital on coast. Attractive personnel policies including 40 hr wk. Salary for California registered nurses starts at $265 and increases on merit rating. Apply Director of Nursing, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

STAFF NURSES: Base salary $335 mo. Higher salaries based upon experience and education. 40 hr work wk, 30 days vacation, 15 days sick leave, 8 holidays, uniform allowance. Write Chief, Nursing Service, Veterans Administration Hospital, Ann Arbor, Mich.

STAFF NURSES: For 45 bed general hospital, completely remodeled and new equipment. 44 hr. week. Starting salary $300 up. Good working conditions. Liberal personnel policy. Apply Administrator, Coon Memorial Hospital, Dalhart, Tex.

STAFF NURSES-OPERATING ROOM NURSES: For modern 650 bed tuberculosis hospital affiliated with Western Reserve University and approved by joint commission on accreditation of hospitals. 40 hr 5 day wk. beginning salary $319 with automatic increases. Fu.l maintenance available at minimum rate. Housing for two or more nurses. Advancement for eligible applicants. Meets approved minimum employment standards of the State Nurses Association. Apply to Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio

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STUDENT HEALTH: (a) Infirmary Nurse, exclusive Women's College, btfl campus, excellent living accom, South. RN2-8 Burneice Larson, Medical Bureau, 900 N. Michigan Ave., Chicago, Ill.

SUPERINTENDENT OF NURSES: Immediate opening. Salary range $439-539. Not over age 50. 250 bed hospital, thoracic diseases and chronic illness rehabilitation. American citizen, Calif. registered. Send personnel record, references and recent photo to Medical Director, Tulare-Kings Counties Hospital, Springsville, Calif.

SUPERVISOR-CENTRAL SUPPLY: New 300 bed hospital opening this spring. Excellent opportunity for qualified, experienced supervisor. Supervisor will organize and set up policies and procedures. Write Box A-140 c/o R.N. Magazine, Oradell, N.J.

SUPERVISORS: (a) Ped, 350 bed fully approved hosp, progressive administration, leading industrial city, near lake resort, Michigan. $5000. (b) General Supervisor, 30 bed community owned hosp. built 1953, prosperous small town, Alaska. $425 mo. (c) Nurse Supv. to manage Rest Home, 40 patients, wealthy Chicago suburb, salary, mtce, plus annual bonus. (d) OR, 350 bed hosp exclusive residential area outside NYC. $5000 up. (e) OB, 150 bed hosp, no teaching, busy dept, modern equipment, Florida. RN2-9 Burneice Larson, 900 N Michigan Ave., Chicago Ill.

SUPERVISORY & GENERAL DUTY NURSES: Gen. hosp. suburb of Wash. D.C. New air-cond. wing. Nearby univ. for continued education. Suburban Hospital, Bethesda, Md.

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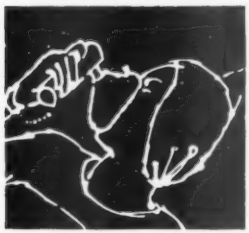

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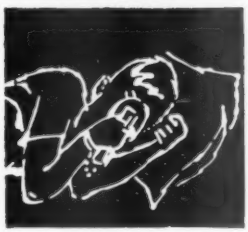

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